

# Annual Adult (18+) Patient Registration Form

Chart # \_\_\_\_\_

We are required to obtain complete updated information on each patient annually.

## Patient's Information

(Entire form to be filled out by the patient.)

First Name	MI	Last Name	DOB	Gender	Preferred Phone #
				M / F	
Race	Hispanic	Social Security #	Email Address		
	Y / N				
Mailing Address		City	State	Zip Code	
Occupation			Employer		

Patient lives with:  Both Parents  Mother  Father  Other (please specify) \_\_\_\_\_

## Consent to Routine Medical Care

I understand and acknowledge that as of my 18<sup>th</sup> birthday, my parents and/or guardians will no longer be permitted access to my medical records, information, providers, or inquire about appointment status without my specific written permission.

Drs. Black and Benton, PSC will not release medical information to my parents without my written authorization in accordance with this document.

### Initial one:

**I DO NOT WISH TO** grant access to my parents / guardians. NO medical information, records, or appointment status information can be discussed or released. I will be responsible for all communications regarding my medical care including making appointments, calling the office nurse and picking up prescriptions or forms.

**I WISH TO** grant the following individuals access to my healthcare providers and/or medical information. (Please list all below.)

First Name	Last Name	Preferred Phone #	Relationship to Patient

## Emergency Contact Information

(Please list someone who is not the patient's parent/guardian and does not live with the patient.)

Name	Relationship to Patient	Preferred Phone #

## Primary Insurance Information

Insurance Company	Subscriber Name	Subscriber DOB	Relationship to Patient
Policy ID	Group #	Beg. Effective Date	Through an employer?
			Y / N

## Secondary Insurance Information

Insurance Company	Subscriber Name	Subscriber DOB	Relationship to Patient
Policy ID	Group #	Beg. Effective Date	Through an employer?
			Y / N

## Courtesy Appointment Reminders should be sent to:

(Texting rates may apply; check with your carrier.)

Name	Cell Phone #	Email Address

## Pharmacy Information

Preferred Pharmacy	Location / Address	Phone Number

(Continued on other side →)

### Parent/Guardian Information

First Name	MI	Last Name	DOB	Gender	Preferred Phone #
				M / F	
Relationship to Patient	Marital Status	Social Security #	Email Address		
Mailing Address (if different than patient)	City		State	Zip Code	
Occupation			Employer		

### Other Parent/Guardian Information

First Name	MI	Last Name	DOB	Gender	Preferred Phone #
				M / F	
Relationship to Patient	Marital Status	Social Security #	Email Address		
Mailing Address (if different than patient)	City		State	Zip Code	
Occupation			Employer		

### Monthly Statements & Billing should be sent to:

Name	Preference	Email Address			
	Email / USPS				
Mailing Address (if different than patient)	City		State	Zip Code	

### Financial Policy

Your insurance policy is a contract between the subscriber and the insurance company; Drs. Black & Benton, PSC are not a party to that contract. Insurance billing is filed by Drs. Black & Benton, PSC one time as a courtesy to the patient. The Patient will be financially responsible for all co-pays and deductibles. The Patient will be held responsible for the entire amount of the insurance claim if the correct insurance information is not provided to Drs. Black & Benton, PSC in a timely manner. It is the responsibility of the Patient to ensure that the providers at Drs. Black and Benton, PSC are in network with the insurance policy. Full payment is expected at time of service if there is not sufficient insurance coverage for the services rendered.

Should a payment default on the account occur, an additional 40% of the defaulted amount will be added to the account for collection agency fees, and if necessary, additional court costs and attorney fees will also be added to the account. In the event this account is involved in litigation, objections to the venue are expressly waived. Set venue will be Knox County, Tennessee.

### Non-Covered Services Policy

The doctors at Drs. Black and Benton, PSC want to provide the best care possible to every patient. There may be services that the provider feels are necessary for the maintenance of good health that are not covered by the insurance contract. It is the responsibility of the Patient to know what is covered by their insurance plan and address any concerns before services are rendered. The Patient will be expected to pay for all services rendered in full within three (3) months of date of service regardless of whether the insurance company has processed the claim.

### Missed Appointment Policy

Please contact our office no less than 24 hours prior to your scheduled appointment if you need to reschedule or cancel. Any missed appointments without 24 hour or more notice will be subject to a \$25 fee which is charged to the patient and not to the insurance company. In addition, if three or more appointments are missed within 365 consecutive days, the Patient is subject to dismissal from the practice.

### Notice of Privacy Practices Policy / HIPAA

Signing below indicates acknowledgement that a copy of the Notice of Privacy Practices Policy / HIPAA has been provided to you to review prior to signing.

Signing below also indicates that you have read and understand the financial and other policies of Drs. Black and Benton, PSC's as described above, and that your included answers on the front of this form are accurate and complete.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Office Use Only	Entered By:	Entered Date: