PATIENT REGISTRATION INFORMATION

Englewood, CO 80113
601 E Hampden Ave, Suite 350

Name: ____ Sex: _____M _______F
First Last MI

Date of Birth:_____________ Age:_____ Social Security (SSN) #: ______________________ Language___________________

Home Address: __________________________________City_________________State_________Zip__________________

Cell:(___)_________________ Work: (____)_______________ Best contact #: _______________________

Employer's Address___________________________________ City___________________ State_____ Zip_________________

Occupation: _____________________________________ Marital Status: __single ___married __divorced __widowed

Is it OK to leave a message on your answering machine at work regarding pathology/ laboratory reports? Yes / No

What is your pharmacy's phone number? _____________________ Ethnicity___________________ Race________________

E mail Address:__________________________ Can we contact you via e mail (appt reminders, office news)? Yes / No

Pt's medical doctor (internist/family doctor)_________________________How did you hear about us?__________________

Do you want to participate in Social Media (Facebook, Twitter, etc) on the latest promotions/developments of our office? Y/N

SPOUSE (OR PARENT/GUARDIAN) INFORMATION

Name: ____ Date of Birth__________ SSN#____________________________

Employer:____Work Phone (___)_______________________________

Employer's Address____City___________________State_____Zip___________________

Person to Contact in Emergency____Phone # _________________________

PAYMENT INFORMATION

Primary Insurance:: __________________________________Address:__________________________________

Policy Holder's Name: _______________________________ ID #: ___________________Group #________________________

Secondary Insurance: _________________________________ Address: ___________________________ID#:___________________

Relation to patient: ___________________________ Group #: _____________________________

PAYMENT POLICY AND AGREEMENT

We expect payment of any deductible, co-payment, or cosmetic procedure at your visit. If your insurance plan is responsible for payment, **please present card to our reception desk**. Although we participate with many insurance companies and bill them for you, we are not responsible for your insurance coverage. Should your insurance deny payment **FOR ANY REASON,** you will accept responsibility for payment in full for any service rendered by the doctor on your behalf. Please be aware that we will bill your insurance as a courtesy and expect full payment upon your receipt of a statement. If you use a credit or debit card to make a payment, your card information will be stored. After two statements have been sent, we will charge the card information on file for the remaining balance. We have a **returned check charge** of $25.00 per check for any check returned unpaid by your bank for any reason. For **cancelled appointments,** we require **24 hours** notice; otherwise a $25.00 charge will be made. A "Collection fee" of $30.00 will be added to unpaid balances that are referred to an outside collection agency. **IF YOU HAVE A DEDUCTIBLE, PARTIAL PAYMENT IS DUE AT TIME OF SERVICE. IF YOU HAVE MET YOUR DEDUCTIBLE, PROOF THAT DEDUCTIBLE HAS BEEN MET WILL NEED TO BE PRESENTED.**

PLEASE SIGN TO ACKNOWLEDGE THAT YOU HAVE READ & ACCEPT PAYMENT POLICY AGGREEMENT:

Signed____ Date ______________________