Patient Registration

Date_____

Hampstead Primary Care
4111 Lower Beckleysville Rd
Hampstead, MD 21074
410-374-0808 . 410-374-0045 fax

_____ I prefer to be called:_____

First Name Middle Name Last Name

Address _____

City / State / Zipcode _____

Date of Birth_____Social Security # _____ Sex: □ Male □ Female

Home Phone _____Work Phone / Extension_____Cell Phone_____

Would you be interested in communication to you sent via email? If so, provide an email address.
Email Address_____

Emergency Contact Name_____Relationship:_____

Home # _____ Work # / Ext _____Cell #_____

Do you authorize this office to discuss your care, treatment or bills with any party besides yourself? □Yes □ No
Authorized Persons:_____

Can we leave personal information on any of the following: □ Home Phone □ Work Phone □ Cell Phone

Employer_____ Work Phone / Ext_____

Previous Medical Provider_____ Phone Number_____

Insurance Information

Primary Insurance Coverage

Insurance Company_____Phone #_____

Policy #_____Group#_____

Insurance Company Address_____

City / State / Zipcode_____

(Subscriber) Person that carries the Insurance_____

Subscriber Date of Birth_____Subscriber SS#_____Relationship to Patient_____

Secondary Insurance Coverage

Insurance Company_____Phone #_____

Policy #_____Group#_____

Insurance Company Address_____

City / State / Zipcode_____

(Subscriber) Person that carries the Insurance_____

Subscriber Date of Birth_____Subscriber SS#_____Relationship to Patient_____

PATIENT NAME_____**DATE OF BIRTH**_____

Preventive Care Visits

Your provider may order tests during your preventive care visit that may not be covered under your preventive care benefits. These tests are covered under your medical benefits.

Additionally, at the time of the preventive care visit your provider may also treat an existing condition or illness. Tests and treatment related to the existing condition or illness may be subject to deductibles, copays and/or coinsurance. _____ initial here

FINANCIAL POLICY

Stephen Laiken M.D., PA, dba/ HAMPSTEAD PRIMARY CARE is dedicated to providing our patients with the best possible care and services while keeping the costs to you from increasing at an unreasonable rate. We ask your help by understanding and cooperating with our financial policy. For more details visit our website at: www.hampsteadpcp.com.

Insurances: We participate with several insurance companies. Please check with the office to see if we participate with yours.

All patients will be responsible for presenting their insurance card at every visit and for completing registration updates semi-annually.

If we Do participate with your insurance company, all services performed in our office will be submitted to them unless we have received prior notification of non-covered services. All copays, co-insurances and deductibles are the patients responsibility. All patients are responsible for ALL copayments at the time of service. Deductibles and co-insurance will be billed to you by our office.

If you do not have insurance or an insurance card is not presented, all services performed will become the responsibility of the patient. Payment for services rendered in the office is due at the time of service.

Records: You will need to request in writing, and pay either $.73 per page or a flat $35.00 (whichever is less), plus the actual cost of shipping/handling if applicable.

Missed Appointment Charge: Patients will be charged a $40.00 no show fee for any missed appointment.

Late Cancellation Fee: Our office requires 24 hour notice of cancellation. Patients will be charged a $20.00 fee for all appointments cancelled on the same day without justification.

Written Prescriptions: All written prescriptions need 24 hours notrice for the provider to write them. Please call our office at least 24 hours ahead of time. There is a $10.00 charge for all prescriptions that have to be written the same day.

It is important for you to understand that your health insurance coverage is an agreement between you and your insurance company and your doctor's bill for the services provided to you is an agreement between you and your doctor.

Payment for services performed:

Our office accepts VISA, MasterCard and Discover for your convenience, as well as cash or a check. Each bounced check will be assessed a fee of $28.00. This fee is the responsibility of the patient and not the insurance company. All co payments not paid at the time of the service will be assessed a service charge of $10.00 per copay. All payments are expected at the time of service and any outstanding balances are due within 30 days of billing, unless prior arrangements have been made. All balances that reach 90 days may be sent to a collection agency. Balances sent to the collection agency will be reported to a credit reporting agency. Should your account be sent to a collection agency, you will be financially responsible for all collection fees that our office incurs through the process utilized to collect the outstanding delinquent Payment in full of any past due balance is expected prior to being seen in our office in the future, unless prior arrangements have been made.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY HAMPSTEAD PRIMARY CARE AND I AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I ALSO UNDERSTAND AND AGREE THAT THE TREMS OF THE FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

_____ _____

Signature of Patient and/or Guardian (SEAL) Date

PATIENT NAME_____**DATE OF BIRTH**_____

Collection Policy

Balances greater than 90 days will be transferred to an outside collection agency unless other arrangements have been made with the office. If your account is transferred to an outside collection agency, you will be responsible for a collection placement fee in addition to the outstanding balance. Once your account has been transferred to a collection agency, any outstanding balance must be paid in full before you can be seen. If you pay your collection balance off and incur a new balance, the balance must be paid in full before you can be seen. If your account was previously in collections and your account is transferred to collections again, you will be responsible for the entire balance and be discharged from the practice. _____ initial here

Patient Insurance Authorization

I authorize STEPHEN LAIKEN, M.D., P.A. dba/ HAMPSTEAD PRIMARY CARE to apply for benefits on my behalf for services rendered by HAMPSTEAD PRIMARY CARE. I request payment from my insurance company be make directly to STEPHEN LAIKEN, M.D., P.A. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked be me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

_____ _____

Signature of Subscriber or Beneficiary Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I choose.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Print Name of Patient's Representative (if applicable) Relationship to Patient