Patient Registration

PLEASE MAKE SURE THE FRONT DESK HAS A COPY OF YOUR INSURANCE CARD AND ID

Patient's Name | SS#

Address | City | State | Zip

Date of Birth | Sex M F | Marital Status S M D W

Cell Phone | Home Phone | Preferred method of contact? Home Cell Work
Preferred method of appointment reminder? Voice Text

Work Phone | E-mail Address | Would you like access to our Patient Portal? Yes No

Guarantor's Name | SS# | Date of Birth

Guarantor's Address | City | State | Zip

Guarantor's Cell Phone | Home Phone

Emergency Contact | Relationship to patient | Phone

Name and location of Pharmacy(ies) most frequently used?

Consent To Treat

By requesting care in Family Doctors of Boulder City, I am giving the health provider and staff permission to examine, diagnose and treat me. I also give authorization for my medication history to be retrieved prior to my appointment. I understand that all the health professionals at Family Doctors of Boulder City are appropriately licensed and will observe accepted professional standard of care.

Patient's/Guarantor's Signature:________________________ **Date:** ____________

Acknowledgement of Financial Responsibility

As a courtesy, insurance claims will be submitted on your behalf to the insurance company you specify during the registration process. We expect all known co-payments and deductibles, except for those due under Medicare/Medicaid or other federal healthcare programs, to be paid at the time of service. We reserve the right to collect copays, deductibles and coinsurance upon notification by the insurer. If you are having financial difficulty or have any questions, please contact our Billing Office to discuss your account. Non-payment of accounts will result in referral to an outside collection agency that could impact the patient's/guarantor's credit record. Legal Fees and collection costs incurred to collect outstanding accounts will be the patient's/guarantor's responsibility.

I have read the above and understand and agree to the terms set forth in this Acknowledgement of Financial Responsibility. I understand that regardless of any insurance coverage I may have, I am ultimately responsible for payment of my account with Family Doctors of Boulder City.

Patient's/Guarantor's Signature:________________________ **Date:** ____________

Acknolwdgement of Privacy Practices

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: 1) Conduct, plan and direct my treatment and follow-up among the multiple providers, agencies and individuals who may be involved in that treatment directly and indirectly. 2) Obtain payment from third-party payors. 3) Conduct normal healthcare operations. I understand that this Practice has the right to change its Notice of Privacy Policy from time to time and that I may contact this facility at any time to obtain a current copy of the Notice. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions but if you do agree, then you are bound to abide by such restrictions.

Patient's/Guarantor's Signature:________________________ **Date:**____________