

# Two Rivers Family Practice

## REGISTRATION FORM

(Please Print and fill this form out in its entirety)

Today's Date:		PCP:	
<b>PATIENT INFORMATION</b>			
Patient's last name:		First: _____	Middle: _____
		Mr. <input type="checkbox"/>	Miss <input type="checkbox"/>
		Mrs. <input type="checkbox"/>	Ms. <input type="checkbox"/>
		Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>	
Is this your legal name?	If not, what is your legal name?	(Former name): _____	Birth date: _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:		Social Security no.: _____	
		Home Phone #: (        ) _____	
		Cell Phone #: (        ) _____	
P.O. box:	City: _____	State: _____	ZIP Code: (include 4 digits) _____
Occupation:	Employer: _____		Employer phone no.: (        ) _____
PHARMACY NAME:		ADDRESS: _____	
PHONE: _____		FAX: _____	
Race: <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> African American <input type="checkbox"/> Other		Preferred Language: _____	
Ethnicity: _____			
Email Address: _____			
EMERGENCY CONTACT (Name & contact phone#): _____			

## INSURANCE INFORMATION

(Please give your insurance card and Drivers License or Picture ID to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different): _____		Home phone no.: (        ) _____			
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:	Employer:	Employer address: _____		Employer phone no.: (        ) _____			
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate name of PRIMARY insurance :							
Subscriber's name:		Subscriber's S.S. no.: _____		Birth date: _____	Group no.: _____	Policy no.: _____	Co-payment: \$ _____
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of SECONDARY insurance (if applicable):		Subscriber's name: _____			Group no.: _____		Policy no.: _____
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

## OFFICE POLICIES / FINANCIAL / BILLING

### FINANCIAL STATEMENT:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Two Rivers Family Practice or my insurance company to release any information required to process my claims.

### SELF PAY PATIENTS:

Those who pay CASH will receive a 20% discount if account is paid in full at time of service. This DOES NOT apply to those patients whom we are filing insurance for, only patients that do not have insurance coverage and are considered self pay.

**HEALTH INSURANCE OFFICE POLICY:** It is the patient's primary responsibility to know which lab, imaging facility, hospital etc. that is in network with their individual insurance plan. Insurers frequently change their benefits and coverage for patients and do not always provide our office with prior notification of the changes; due to this it is also the patient's responsibility to know what their co-payments are and or deductibles are at the time of the office visit. Our office will assist the patient to the best of our ability with verification of benefits. It is also our office policy to collect at time of service for all co-payments and or deductibles; we do not bill for co-payments for office visits.

### OFFICE POLICIES:

Two Rivers Family Practice has hours of operation Monday Through Thursday from 8am to 5pm and on Friday from 8am to 12pm. There will be an on call provider available for emergencies only through the after hour's answering service. In the event of inclement weather conditions that does not allow travel on the causeways, telephone assistance will be provided during the above noted operating hours, and the on call options also apply. *A charge of \$30.00 will be charged on all RETURNED CHECKS.* \*\* PLEASE NOTE: if your account becomes delinquent or unpaid for more than 60 days without confirmation of a payment agreement we reserve the right to discharge you from the practice due to non-compliance.

**LABS, IMAGING AND SPECIALIST PHYSICIAN REFERRALS - ORDERED BY PHYSICIAN DISCLAIMER:** please note that all Labs and or Imaging ordered by the physician will require a follow up appointment to discuss results; this must be done within two weeks of the testing. It is the patient's primary responsibility to know which lab is in network with your individual insurance plan, and please make sure that a follow up appointment is made and kept; if cancellation occurs the patient must follow up with a rescheduled date. The physician does not assume responsibility for the patient's inability to follow up after testing has occurred. It is also the patient's responsibility to notify the office if they do not receive appointments for testing and or referrals within two weeks of the office appointment where the referral was generated. I have read and understand this information, and accept responsibility.

### MEDICATION REFILL STATEMENT:

I am aware that requests for refills including antibiotics and pain medications are to be made during business hours.

### HOSPITAL PRIVILEGES:

Please note that Dr. Capraro **does not** admit nor has privileges at any of the area hospitals, she does however utilize the services of the attending physicians at our local hospitals who may admit for her.

*Patient/Guardian signature:*

*Date:*