PATIENT REGISTRATION FORM

ACT MEDICAL GROUP
Dedicated to Advanced Cancer Care

Patient Name: ____________________ ________________ ______ Date of Birth: ____/____/____
(Last) (First) (Mi)

Social Security# __________-__________-__________ Sex: __________Male __________Female

Address: ____ City: ____________________

State: ________ Zip: __________ Marital Status: _______Single _______ Married _______Other

Spouse's Name: __________________________ Spouse's Employer: _______________________

Home Phone: (________) ___________________Work Phone: (________) ___________________

EMPLOYMENT INFORMATION

Employer Name: ____

Employer Address: ____

Occupation: ____

Status: _____Full Time _____Part Time _____Retired _____Unemployed

GUARANTOR INFORMATION

(Individual responsible for payment, if different than patient)

Patient Relationship to Guarantor: ________Self ________Spouse ________Child ________Other

Name: ______________________ _________________ ______ Date of Birth: _____/_____/______
(Last) (First) (Mi)

Sex: ___________ Male ___________ Female Social Security# _______/_______/________

Address: ____ City & State: ______________________

Zip: ____________Home Phone#: (______) ___________ Work Phone#: (____) ______________

Guarantor's Employer: ____

Employer Address: ____

Employment Status: ________Full Time _______Part Time ________Retired ________Unemployed

Emergency Contacts: 1. ______________________________________ Phone# (___) _____________

2. _______________________________________Phone# (___) ______________________________

PLEASE REMEMBER WE NEED A COPY OF YOUR INSURANCE CARD!

INSURANCE INFORMATION

PRIMARY Insurance Name: ______________________________

Claim Mailing Address: ______________________________

____

City: ____________ State: ________ Zip: ________ Phone#: (____) ____________

GROUP #: ______________________ **POLICY #:** ______________

Insured Name (if different than patient): ______________________

Date of Birth _____/_____/_____ Sex: __________Male __________Female

Address (if different than patient): ______________________

SECONDARY Insurance Name: ______________________________

Claim mailing address: ______________________________

____

City: ____________ State: ________Zip: ________ Phone #: (____) ____________

GROUP # ______________________ **POLICY #:** ______________

Insured Name: ______________________________

Date of Birth: ______/______/______ Sex: __________Male __________Female

Address: (if different than patient) ______________________

____

THIRD Insurance Name & Address: ______________________

____

GROUP # ______________________ **POLICY #:** ______________

Primary Care Physician ______________________________

Referring Physician (if other than PCP) ______________________

For the following please give dates and attending physician if known.

Please list your past illnesses and injuries:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

Please list your past surgeries / hospitalizations:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

Stool tested for blood? Yes ☐ No ☐ Date ________

Flexible sigmoidoscopy? Yes ☐ No ☐ Date ________

Colonoscopy? Yes☐ No ☐ Date____________

Had a blood transfusion? Yes ☐ No ☐

Had problems with anesthesia? Yes ☐ No ☐

Women Only:

First period age: ________ First pregnancy ________

No. of pregnancies: _____ No. of lost pregnancies: _____

Do you use contraceptives? ________ Yes ☐ No ☐

Have you ever had any sexually transmitted infections?

Yes ☐ No ☐ ______________________

Menopause age: ______________________

Have you had a pap smear? ______________________

When was your last mammogram? ______________________

Men Only:

Last prostate exam and results ______________________

____

Have you ever had any sexually transmitted infections?

Yes ☐ No ☐ Type: ______________________

Do you use contraceptives? ____________ Yes ☐ No ☐

Other information: ______________________

____

____

Medication (prescribed and over the counter).

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________

Medication allergies (what type of reaction)?

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________

Relationship	**Age or age of Death**	**Current diseases or cause of death.**
Father		
Mother		
Siblings		
Other		

Check box if your blood relatives ever had.	Relationship
☐ Asthma, hay fever	
☐ Cancer / if yes what types.	
☐ Diabetes	
☐ Stroke	
☐ Heart Disease	
☐ High Blood Pressure	
☐ Other	

Immunizations:	Date:	Immunizations:	Date:
Tetanus	________	Pneumovax	________
Hepatitis	________	MMR	________
Polio	________	TB Skin Test	________

Personal Habits

Are you retired? Yes ☐ No ☐ Do you wear a seatbelt? Yes ☐ No ☐

Have you traveled outside of the U.S. in the last two years? Yes ☐ No ☐

Have you ever smoked? Yes ☐ No ☐ How much? ________ How long? ________ if quit, when? ________

Do you regularly drink alcohol? Yes ☐ No ☐ What kind? ________ How much? ________

Do you regularly drink caffeinated beverages? Yes ☐ No ☐ How much? ________

Do you use recreational drugs? Yes ☐ No ☐ What kind? ________

Are you on a special diet? Yes☐ No ☐ What kind? ________

Do you have a living will? Yes ☐ No ☐ If so, please provide a copy to the doctor.

Other information that may be helpful to the doctor. ________

What are your current symptoms or concerns regarding your health, spiritual, financial, insurance, etc.

The above information is accurate to the best of my knowledge:

Patient signature ________ Date ________

Physician ________ Date ________

S:/Business Office/Forms/Registration 9/20/2002 vjs

ACT Medical Group, S.C.

Release of Information/Financial Policy

Thank you for choosing ACT Medical Group, S.C. as your health care physicians. The following is a statement of our Release of Information/Financial Policy which we require you read and sign prior to any treatment. All patients must also complete and sign our Patient Registration Form.

RELEASE OF INFORMATION/MEDICAL RECORDS

By signing this form, you authorize ACT Medical Group, S.C. or his/her designee(s) to release and disclose such medical records, information and documentation as may be necessary or appropriate in order to process insurance claims and to obtain payment on your behalf. You also authorize the release of information acquired in the course of your examination or treatment and all information pertaining to your history and progress in your case. This includes any alcohol or drug abuse data that may be protected by Federal Regulations - 42CFR Part 2. You agree that a photocopy your original authorization shall be considered equally authentic.

REGARDING INSURANCE

We cannot bill your insurance company unless you provide us with your insurance information and any special claim forms required by your insurance company. We accept assignment of insurance benefits. That means your insurance will pay us directly the amount due based upon your benefit coverage. By signing this form, you authorize assignment of your benefits to ACT Medical Group, S.C. for treatment and related services. However, we do require, as your insurance benefits require, payment of copays, co-insurance and deductibles at the time of service. Your insurance policy is a contract between you and your insurance company. *Please know your benefits. Please be aware that only your insurance company can tell you if the services provided are covered under your benefit plan.*

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. In the event that your account is turned over to an outside collection agency, you will be responsible for an additional 30% of the balance owed and/or all the attorney fees and costs incurred to collect the unpaid debt.

Those Insurance Plans in which we are a Participating Physician.

All co-pays and deductibles are due at the time of treatment. Prior to seeking payment from you, we will work with these plans to obtain payment. In the event that your insurance coverage changes to a plan in which we are not a participating physician, refer to the paragraph below. You may contact our office at any time to obtain a list of plans that we participate in.

Those Insurance Plans in which we are NOT a Participating Physician.

If your insurance company has not paid your account in full within 45 days of the billed date, the balance is your responsibility. Your assistance in collection from your insurance company may be required.

WE ACCEPT PAYMENT IN THE FORM OF CASH, PERSONAL CHECK, VISA & MasterCard

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. The federal government agency that administers the Medicare and Medicaid programs, has determined that except for certain circumstances, the discounting or waiving of a patient's co-pay or deductible is unlawful. Additionally, under the new HIPAA regulations, we are now not allowed to discount or waive patient's co-pays or deductibles as outlined by benefit plans offered by other third party payors. You are ultimately responsible for payment.

PATIENT BALANCES

Patients are responsible for full payment at the time of service if not covered by some other third party such

Refunds

Due to the nature of our long-term relationships with our patients, we will issue refunds on a monthly basis unless a specific request is made.

Co-Payments

Co-payments are due at the time of service. It is your responsibility to verify with
your insurance company what services requires a co-payment. ACT Medical Group accepts VISA, MasterCard, Cash and Check.

Cases Involving an Attorney

If you are receiving services related to an auto accident, worker's compensation case or personal injury and you are working with an attorney, we expect a minimum monthly payment of $25 in order to continue treatment and hold your account without involving a collection agency. We also require information relating to your group health coverage. Both your group health and the appropriate auto/worker's compensation carrier will be billed at the same time. This procedure is necessary in order to have a claim on file with the group health in case the auto/worker's compensation carrier does not pay or is exhausted at some point during your treatment. This procedure not only protects ACT Medical Group, S.C., but you as the patient from the timely filing limits of group health coverage.

Missed Appointments

Please help us serve you better by keeping scheduled appointments. We recognize there are times when it is not possible to keep appointments. If you are not able to keep an appointment, please call our office at least 24 hours prior to the appointment time. If you ***NO SHOW*** for your appointment, *without calling,* you will be charged for the office visit. You will be permitted one no show without being charged.

Late Appointments

To help maintain a punctual schedule and reduce wait times you *may* be asked to reschedule your appointment if you are more than half an hour late.

Forms

There is a $25.00 fee to fill out Family Medical Leave and Disability forms.
A $20.00 fee will be charged for copies of Medical Records for your personal use. (15 pages or more)
Payment in advance is required. Insurance companies and Attorney's will be charged directly. There is no charge to transfer records to another Physician. Please call in advance with your requests.

Durable Medical Equipment (DME)

ACT Medical Group, S.C. is a participating provider in Medicare's Part B program as well as Medicare's DME program. If you are a patient who is covered by Medicare and requires durable medical equipment (i.e. splints, exercise equipment, etc.), we will bill Medicare directly for this equipment.

I have read the Release of Information/Financial Policy. I understand and agree to this Release of Information/Financial Policy:

X ______________________________ Date ______________________________
Signature of Patient or Responsible Party

X ______________________________
Print Name

X ______________________________ Date ______________________________
Signature of Co-Responsible Party