PATIENT REGISTRATION FOR DR. JAMES E. PHILLIPS

PATIENT NAME:________________________________SS#________________________________

STREET ADDRESS____

CITY______________________________STATE_________________ZIP_____________________

DATE OF BIRTH____________________MARITAL STATUS: S/ M/ D/ SEP/ WIDOWED

EMAIL____

TELEPHONE: HOME________________OFFICE________________CELL___________________

IS IT OK TO CALL ANY ONE OF THESE NUMBERS TO REACH YOU?_____________________

MAY WE LEAVE A MESSAGE IF WE DO NOT CONTACT YOU DIRECTLY? YES ____ NO ____

SPOUSES NAME____

SPOUSES EMPLOYER NAME & ADDRESS____

EMERGENCY CONTACT_________________________TELEPHONE________________________

RELATIONSHIP TO PATIENT ____

PATIENT EMPLOYER INFORMATION

EMPLOYER’S NAME____________________________TELEPHONE # _____________________

EMPLOYER’S ADDRESS ____

CITY______________________________STATE_________________ZIP_____________________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN THE PLACE OF THE ORIGINAL AUTHORIZATION FORM.

DATE:__________________________________SIGNATURE:______________________________

I HEREBY AUTHORIZE DR. JAMES PHILLIPS TO APPLY FOR BENEFITS ON MY BEHALF FOR ANY COVERED SERVICES RENDERED BY HIM, OR BY HIS ORDER. I REQUEST THAT PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO DR. (OR TO THE PARTY WHO ACCEPTS ASSIGNMENT). I PERMIT A COPY OF THIS AUTHORIZATION TO BE ISSUED IN PLACE OF THE ORIGINAL. THIS AUTHORIZATION MAY BE REVOKED BY EITHER ME OR MY INSURANCE COMPANY AT ANY TIME IN WRITING.

DATE:__________________________________SIGNATURE:______________________________

FINANCIAL AGREEMENT FOR DR. JAMES E. PHILLIPS

DATE:____

I/We Hereby Agree as Follows:

1. **GUARANTEE OF PAYMENT:** Medical care has been or will be provided to the patient whose name appears below. I/We both jointly and individually shall be responsible for payment for the patient's bill with Dr. James E. Phillips, based on the charges posted which I /We agree are fair and reasonable. Dr. James E. Phillips may demand full payment of the patient's bill at any time. Even if Dr. James E. Phillips does not demand immediate payment, my/our obligation to make such payments remain the same.
2. **WHEN THE PATIENT'S INSURANCE COVERAGE IS INSUFFICIENT:** If any insurance coverage which the patient may have rejects the patient's claim or allows only part of the claim, I/We shall be responsible for immediate payment of the balance due, as determined by Dr. James Phillips.
3. **NO SHOW APPOINTMENTS:** Failure to call and notify the office of cancellation of any scheduled appointment shall result in a $25.00 no show fee. This fee is not converted by insurance; it is the patient's responsibility.
4. **COPYING OF RECORDS:** There is a fee for copying records. It is determined per page and is charged at the current rate allowable by law. This fee is not covered by insurance. It is patient's responsibility.

NAME OF PATIENT____

NAME OF PERSON GUARANTEEING PAYMENT ______________________________________

SIGNATURE OF PERSON GUARANTEEING PAYMENT_________________________________

HOME ADDRESS ____

TELEPHONE NUMBER ____

WITNESS ____