PATIENT REGISTRATION FORM

PATIENT INFORMATION: THIS SECTION REFERS TO THE PATIENT ONLY

Last Name: _____ First Name: _____ MI: _____

Social Security Number: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Mailing Address: _____
Address City State Zip Code

Physical Address: _____
Address City State Zip Code

Home Phone: (_____)_____ Cell Phone: (_____)_____ Email: _____

Employer Name: _____ Work Phone: (_____)_____

Primary Care Physician's Name (if applicable): _____ Clinic Name: _____

I authorize International Health Providers (IHP) to contact me (and leave messages regarding appointments of other general information) via: ☐ Email ☐ Home Phone ☐ Cell Phone ☐ Work Phone

EMERGENCY CONTACT

Name: _____ Relationship: _____Phone Number: (_____)_____

Name: _____ Relationship: _____Phone Number: (_____)_____

INSURANCE INFORMATION

Primary Insurance: _____ Policy No: _____ Effective Date:_____

Subscriber Name: _____ Subscriber's DOB: _____

Subscriber's SS#: _____ Subscriber's Contact Number: (_____)_____

Secondary Insurance: _____ Policy No: _____ Effective Date:_____

Subscriber Name: _____ Subscriber's DOB: _____

Subscriber's SS#: _____ Subscriber's Contact Number: (_____)_____

GUARANTOR INFORMATION: RESPONSIBLE ADULT FOR MINOR PATIENTS (18 & Below)

Relationship to Minor: ☐ Parent ☐ Legal Guardianship ☐ Other (Skip to next section) _____

Last Name: _____ First Name: _____ MI: _____

Social Security Number: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Mailing Address: _____
Address City State Zip Code

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

Employer Name: _____

AUTHORIZATIN TO RELEASE INFORMATION

I the patient or the authorized party to act on the behalf of the patient to sign this document verifying consent to the above terms. I acknowledge and agree and that the practice may disclose my PHI and medical record information to the following individuals who are my family members, legal representatives, guardians, healthcare surrogates, or have power of attorney on my behalf (please list all applicable names):

Name: _____ Relation:_____

Name: _____ Relation:_____

PATIENT FINANCIAL POLICY

Thank you for choosing International Health Providers as your healthcare provider. We are honored by your choice and are committed to providing you with access to the highest quality health care. We ask that you read and sign this form to acknowledge your understanding of your patient financial responsibilities.

We will bill all accepted primary and secondary insurance companies so as the provided paperwork is properly completed, and all insurance information is correct. If an insurance carrier has not paid within 60 days of billing, professional fees are and payable in full from you to include any noncovered services. **Required Deductibles, Co-Insurance, Co-Payments and Non-Covered Services are due at the time of the visit. ALL PATIENTS WITH OFF-ISLAND INSURANCE: are required to pay 100% of the services at the time of visit.** For your convenience we accept cash, most major credit cards & PayPal. Any and all balances assigned as patient responsibility may be subject to collections efforts after 90 days, as well as credit reporting. Should your insurance carrier send payment directly to you, it is your responsibility to forward payment directly to International Health Providers (IHP).

REQUIRED DEPOSITS AT CHECK-IN

If your plan requires a **Deductible** and has not been met at the time of service $150 deposit is required		**Co-Insurance** $25 deposit is required
Co-payment Your plan's required Co-Payment	**Self-Pay** $150 deposit is required	**Off-Island Insurance Carriers** $150 deposit is required

Patients may incur and are responsible for the payment of additional charges. These charges may include (but not limited to)

Returned Checks $35	**Missed appointments** without 24-hours advance notice $25	**Payments using PayPal** Service Fee $5 in addition to your balance
Walk-Out: A $50 fee will be applied to your account if you leave the clinic without discharging with our cashier		
COMPLETION OF FORMS $25: to complete physical/pre-employment/sports physicals/insurance request forms/disability (and or any other type of form) that are not presented at the time of visit. Please allow 5-10 business days for completion.		
MEDICAL RECORDS: Request for medical records must be made in writing and a deposit of $25 is required upon request (please allow 72 hours for completion).		

Patient Statement and Authorization: I hereby authorize International Health Providers (IHP) to release medical and other information acquired in the course of my examination to the necessary insurance companies, third-party payors, and/or other physician or healthcare entities required to participate in my care. I hereby authorize assignment of financial benefits directly to International Health Providers (IHP). I authorize my insurance company to make payment directly to International Health Providers (IHP) for medical services I receive. I understand that I am financially responsible for payment of non-covered services, co-payments, co-insurance, deductible and any other charge(s) my insurance company deems my responsibility or out of pocket responsibility such as self-pay. In the event that my account should become delinquent for a period of 30 days or more, I hereby acknowledge that I will be responsible for the entire balance, interest, court costs, and/or attorney fees involving the attempt to collect debt.

_____ _____ _____

Print Name of Patient or Legal Guardian **Signature of Patient or Legal Guardian** **Date**