Registration

Patient Information

Legal Name: Last ____First______________________________________MI___________

Mailing Address____Physical Address____

City____ State____________________ Zip Code _________________________

Home Phone ____ Work Phone ____

Employer____ Occupation ____

SS# ____ Birth Date _________________________________ Sex _____________________

Marital Status ________________________ Relationship to acct holder ____

May we leave a message at your home phone? _______ With whom may we leave a message?_____________

Account Holder Assuming Financial Responsibility (Parent or Legal guardian of Patient is a minor)

Name: Last ____First__________________________________MI____________________

Address: ____

City____ State________________Zip Code__________________________

Home Phone ____ Work Phone____

Employer____ Occupation ____

Insurance Information: **Please give your insurance card to receptionist**

Name of Company____ Address ____

Policy Holder Name ____ SS# _______________________________________

Date of Birth ____ Relationship to patient _________________________________

ID# ____ Group # ____

Emergency Contacts: Please list two

Name ____ Phone____

Address ____ Relationship to patient____________________________

Name ____ Phone____

Address ____Relationship to patient____________________________

Agreement: Please read carefully and sign at the bottom.

I consent to treatment necessary for the care of the above-named patient. I authorize release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittal of medical records, if necessary.

I acknowledge full financial responsibility for services rendered by Dr. David Jones, Dr. Leslie Stone, and Dr. Michael Stone. I understand that payment of charges is due at the time of service, unless prior arrangements have been made. As a service to the patient we will bill primary insurance only. I authorize and request that insurance payments be made directly to Dr. David Jones, or Dr's Leslie and Michael Stone should they elect to receive such payment.

A 1.5% service charge will be added to unpaid balance of 60 days or more.

- ◆ I acknowledge full financial responsibility for services rendered by to Dr. David Jones, and Dr's Leslie and Michael Stone and authorize all unpaid amounts to be billed to my credit card after 120 days from the date of service. **(Optional)**

Company: ____ Card #: ____

Name on Card ____ Exp. Date: _________________________

Please be aware that we require 24 hour notice for appointment cancellations. You will be billed for your visit if fail to honor this request. Initial: _________________

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

Date: __________________________ Signature: ____