Seapoint Family Healthcare

PATIENT REGISTRATION

Name: ______________________________ **Date of Birth:** ______________
Sex: ________ **SSN:** ____________________ **Marital Status:** ______________
Race: ___________ *or* Decline to answer **Hispanic:** (circle one) Yes. No. Decline

Mailing Address: ____
City: ____________________ **State:** _______ **Zip Code:** _________
Home Phone: ______________ **Cell:** ____________ **Work:** ___________

Emergency Contact
Name: ______________________
Relationship: __________________
Phone: _______________________

Guardian (if applicable)
Name: ______________________
Relationship: __________________
Phone: _______________________

Primary Insurance Carrier: ______________________________________
Member ID:______________________ **Group:** ______________________
Subscriber: ______________________ **Subscriber D.O.B:** _______________

This practice uses an online Patient Portal to provide our patients with their medical records, test results, and other correspondence in a timely manner. Please provide your best email address so that we may register you.
Email: ____

How did you hear about us: _______________________________________

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I certify that the above information is true and complete and I consent to treatment by Susan Krolewski, MD, PLLC.

I understand that all medical care providers are required by law to maintain the privacy of protected health information and provide me notice of their legal duties and privacy practices regarding health information about me. I have read, understood and agree with the Notice of Privacy that describes how medical information about me may be used and disclosed and how I can have access to this information.

I authorized the release of all medical information necessary to process my insurance claim(s). If applicable I assign all insurance payments for services rendered to be paid directly to Susan Krolewski, MD, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I understand that insurance companies will be billed as a courtesy to me and that patients are responsible for knowing their insurance benefits and whether services are covered. I am responsible for providing accurate insurance information at the time of my visit and to notify my insurance company of my PCP selection if applicable. If payment is denied due to inaccurate information or my failure to notify my insurance of my PCP selection I am responsible for my payment. I understand that I am financially responsible for all changes and/or balances due after my insurance payments. If the patient is a minor I understand that as parent or legal guardian I am responsible for all payments. I agree that in the event my account becomes delinquent, I will be responsible for late fees, collection fees and/or attorney/court fees. There will be a charge for returned checks. There will be a $25 fee for missed appointments, 3 missed appointments may result in discharge from the practice. A $15 for the first 30 pages and .25 per additional page is charged for copies of medical record.

Signed: ______________________________ **Date:** ______________
(Patient, or if minor, parent or legal guardian)