

(PLEASE PRINT)

NEW PATIENT  ESTABLISHED PATIENT

Today's Date: \_\_\_\_\_ Patient Chart No: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Male  Female  Single  Married  Divorced Email: \_\_\_\_\_

Race:  African American  Asian  Caucasian/White  Declined  Unknown  
 Native Hawaiian/Other Pacific Islander  American Indian/Alaska Native

Primary Language:  English  Spanish  Other: \_\_\_\_\_

Ethnicity:  Hispanic  Non-Hispanic  Declined  Unknown

Current Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Emergency Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security No: \_\_\_\_\_

Primary Insurance Name: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_

Does this insurance replace your current policy?  Yes  No

Is the patient the subscriber of the policy?  Yes  No

**If no, subscriber information required below:**

Name of the Subscriber: \_\_\_\_\_

Relationship to the Patient: \_\_\_\_\_

Subscriber DOB: \_\_\_\_\_ Subscriber SSN: \_\_\_\_\_

Effective Date of Policy: \_\_\_\_\_

Employer of Subscriber: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

**OFFICE USE ONLY**

**Does the patient have an outstanding balance?**  Yes  No

Time of Appointment: \_\_\_\_\_ Time Signed In: \_\_\_\_\_

Time Given Paperwork: \_\_\_\_\_ Time Paperwork Returned: \_\_\_\_\_

Time Registration Began: \_\_\_\_\_ Time Registration Completed: \_\_\_\_\_

Insurance Verified: \_\_\_\_\_

**FINANCIAL ARRANGEMENTS AND INSURANCE**

We are committed to providing you with the best possible care. If you have medical insurance, we would like to help you receive your maximum allowable benefits. In order to achieve this, we need your assistance and your understanding of our payment policy.

Payment is due at the time of services are rendered unless payment arrangements have been approved in advance by our business office. We accept cash, checks, MasterCard and Visa. We will be happy to help you process your insurance claim. Changes in insurance data should be directed to our insurance clerks. In most instances, we will accept assignment of primary and secondary insurance benefits.

However, you must realize:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees fall within the acceptable range by most insurance companies and therefore should be covered to the maximum allowance determined by each carrier.
3. Some services may not be covered by your insurance contract and you may be responsible for payment of those charges.
4. We may need to release medical information concerning you to your insurance carrier as part of the processing of your claim. By signing this form, you consent to the release of such information for that limited purpose.

**We must emphasize that as medical care providers, our relationship is with you, not your insurance company. 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. All co-pays are due at time of service. There is a fee for returned checks.**

Past due accounts will be turned over to an agency for collection unless payment arrangements have been made with the business office. During that time, your future status with the clinic will be considered.

By signing this form, you agree to reimburse The Valley Foundation the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

We value you as a patient and will continue to provide you with our best professional care.

If you have any questions about the above information, please do not hesitate to ask us. We are here to help you.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_