

Registration Form

For individual patients, complete patient, contact and responsible party sections below. Please complete all areas for families.

Date Completed: _____

P A T I E N T	Legal Name: Last		First	Initial	Social Security #
	Address				Home Phone #
	City	State	Zip Code	Marital Status	How did you hear about us?
	Work Phone	Extension		Cell Phone #	Occupation
	Employer or School				E-Mail Address
	Employer or School Address		Date of Birth		Physician
R E S P O N S I B L E P A R T Y	Legal Name: Last		First	Initial	Social Security #
	<input type="checkbox"/> Same as Patient				
	Address				Home Phone #
	City	State	Zip Code	Marital Status	Relationship to patient
	Work Phone	Extension		Cell Phone #	Occupation
	Employer or School				Employer #
Employer or School Address		Date of Birth		Physician	
C O N T A C T	Emergency Contact		Work Phone	Phone #	Cell Phone#
	Emergency Contact		Work Phone	Phone #	Cell Phone#
Spoken Language <input type="checkbox"/> English Speaking <input type="checkbox"/> Non English Other <input type="checkbox"/> Spanish Speaking <input type="checkbox"/> Vietnamese Speaking			Race: <input type="checkbox"/> African-American <input type="checkbox"/> Hispanic <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> African <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Caucasian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Unknown		

Authorization to pay benefits to the physician and release of information:

I hereby instruct and direct _____ Insurance Co. to pay by check made out and mailed to Professional Financial Services, 245 State Street, Grand Rapids, MI 49503. If my current policy prohibits direct payment to my doctor, then I hereby also instruct and direct you to make out the check payable to Professional Financial Services and myself. Send the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A photocopy of this assignment shall be considered as effective and valid as the original.

I authorize Saint Mary's Health Care to release any medical information required during the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. I understand that my payment is expected at the time of service. This includes but is not limited to coinsurance, co - payment, deductible, and non-covered services.

Policy Holder Signature _____

Date _____

Spouse Signature _____

Date _____

Medicare Authorization:

I hereby authorize payment of Medicare benefits to be made directly to SMHS Professional Services for any services rendered to me by providers employed by that corporation. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed for the purpose of determining these benefits. I understand that this authorization is in effect until revoked, in writing, by me.

Beneficiary Signature _____

Date _____

Beneficiary Signature _____

Date _____

Saint Mary's Healthcare and Advantage Health, as partners in your health care needs, may share certain computerized information, including patient name, address, insurance, and employer. Please be assured we will manage your information appropriately and confidentially.