# MEYER FAMILY MEDICINE ASSOCIATES
## PATIENT REGISTRATION FORM

(Please Print)

### PATIENT INFORMATION

| ☐ Mr. ☐ Mrs. | ☐ Miss ☐ Ms. | Patient's last name: | First name: | MI |
|---|---|---|---|---|

| Maiden name: | Marital status (circle one) Single / Mar / Div / Sep / Wid | | Date of birth: / / | Age: | Sex: ☐ M ☐ F |
|---|---|---|---|---|---|

| Street address or PO box: | City: | State: | ZIP Code: |
|---|---|---|---|

| Social Security no.: | Home phone no.: ( ) | Cell phone no: ( ) | Email address: |
|---|---|---|---|

| Occupation: | Employer, company name & address: | Employer phone no.: ( ) |
|---|---|---|

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr. _____ ☐ Insurance Plan ☐ Hospital

☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

Other family members seen here:

### INSURANCE / GUARANTOR INFORMATION

(Please give your insurance card to the receptionist.)

| Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: ( ) |
|---|---|---|---|

Is this person a patient here? ☐ Yes ☐ No

| Occupation: | Employer: | Employer address: | Employer phone no.: ( ) |
|---|---|---|---|

Is this patient covered by insurance? ☐ Yes ☐ No Insurance Company:

| Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $ |
|---|---|---|---|---|---|

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

| Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.: |
|---|---|---|---|

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

### PHARMACY INFORMATION

| Preferred local or mail-order pharmacy | Address: |
|---|---|
| Phone number: ( ) | Fax number: ( ) |

### IN CASE OF EMERGENCY

| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work or cell phone no.: ( ) |
|---|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize MEYER FAMILY MEDICINE Associates or insurance company to release any information required to process my claims.

*Patient/Guardian signature* _____ *Date* _____

Meyer Family Medicine Associates, LLC
Oak Mill Mall, Suite 2-23
7900 N. Milwaukee Ave.
Niles, IL 60714
(847) 966-9878

Paul A. Meyer, D.O.
Michael J. Meyer, D.O.

Board Certified Family Practice

I, _____(Name of patient or authorized agent), hereby give my consent to Dr. Paul A. Meyer, D.O. and Dr. Michael J. Meyer, D.O. to use or disclose, for the purpose of carrying out treatment, payment of health care operations, all information contained in the patient record of _____ (Patient's name).

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided at me at the next direct patient encounter after revision or upon request beginning on the revision's effective date. A Revised Notice will be in the practice's reception area on the revision's effective date.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient: _____

# MEYER FAMILY MEDICINE
# Payment Policy and Authorization

I understand that all charges incurred are the personal responsibility of the patient/guarantor. I authorize payment for services rendered to be paid directly to the physicians and if correct information is supplied at the time of visit, that managed care insurance is filed. The patient/guarantor is responsible for all residual balances including but not limited to copays, deductibles, coinsurance and charges not paid by insurance carrier for any reason, after consideration of contractual adjustments.

Patients without insurance are required to sign and guarantee a contract for care with their credit card or pay in full at time of service and to make the required payments as outlined in the contract. Non-guaranteed contracts are payable in-full at contract signing time. Other services, not covered as part of care are due payable at the time services are rendered.

In addition to the principle amount owed. I agree to pay 33.33% of the unpaid balance as collection fees if my account is turned over to a collection agency. I further agree to pay reasonable attorney fees and cover costs arising out of any litigation concerning the collection of this account.

I acknowledge that I have fully read and understand all the terms and conditions, as well as any charges and payment terms associated with this contract, and hereby agree to be bound by all of the above terms.

Signature: _____ Date: _____

**AUTHORIZATION TO RELEASE INFORMATION:**

I authorize the physicians to release any information needed, including the diagnosis and records of any treatment/examination rendered to me or my dependents to secure payment of benefits.

Signature: _____ Date: _____

I understand that there will be a charge of $25.00 if a scheduled appointment is not cancelled at least 24 hours in advance.

Signature: _____ Date: _____

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