

PATIENT REGISTRATION

PATIENT INFORMATION

Name: _____
 Address: _____

 City: _____ State: _____ ZIP: _____
 Email Address: _____
 Date of Birth: ____/____/____ Sex: M F
 Resp Provider: _____
 Race: _____

PATIENT EMPLOYMENT

Employed Full Time Part Time
 Employer: _____
 Phone: () ____ - ____ Work Other
 Occupation: _____
 Retired Unemployed Other _____

GUARANTOR

Same as Patient If Other than Patient
 Name: _____
 Address: _____
 City: _____ State: _____ ZIP: _____
 Date of Birth: ____/____/____

PRIMARY INSURANCE

Same as Patient Same as Guarantor Other
 Subscriber: _____
 Insured Phone: () ____ - ____ Home Work Other
 Company: _____
 Relationship to Primary Insured/Guarantor: _____

Subscriber Information Required

Social Security #: _____ - _____ - _____
 Insured ID: _____
 Policy Group: _____

**** Date of Birth: ____/____/____ Required**

Patient Signature: _____

Marital Status: Married Single Divorced
 Phone: () ____ - ____ Home Work Cell
 Phone: () ____ - ____ Home Work Cell
 Phone: () ____ - ____ Home Work Cell
 Contact By: Phone Email Letter

Social Security #: _____ - _____ - _____
 Preferred Language: _____
 Referral Source: Patient Yellow Pages Website
 Physician Physician Match Care Station Ad
 Other _____

EMERGENCY CONTACTS

1) Name: _____
 Relationship: _____ Phone: () ____ - ____
 2) Name: _____
 Relationship: _____ Phone: () ____ - ____

Employer: _____
 Phone: () ____ - ____ Home Work Other
 Alt Phone: () ____ - ____ Home Work Other
 Social Security #: _____ - _____ - _____
 Contact By: Phone Email Letter

SECONDARY INSURANCE

Same as Patient Same as Guarantor Other
 Subscriber: _____
 Insured Phone: () ____ - ____ Home Work Other
 Company: _____
 Relationship to Primary Insured/Guarantor: _____

Subscriber Information Required

Social Security #: _____ - _____ - _____
 Insured ID: _____
 Policy Group: _____

**** Date of Birth: ____/____/____ Required**

Date: _____

FINANCIAL RESPONSIBILITY STATEMENT

ASSIGNMENT OF INSURANCE BENEFITS: In consideration of the medical services rendered by Little Company of Mary Affiliated Services, Inc., I hereby assign, transfer and give to Little Company of Mary Affiliated Services, Inc. all of my rights, title and interest to medical expense reimbursement benefits under any insurance policy, ERISA Plan, Medicare Benefits, or any other public or private health care benefit indemnification program or agreement otherwise payable to me for those services rendered by Little Company of Mary Affiliated Services, Inc. This agreement specifically includes, but is not limited to, an assignment of the rights to designate a beneficiary, add dependent eligibility, obtain payment of any auto or other third party liability policy medical expense benefits due for this treatment and to have an individual or group policy converted or continued in accordance with its terms and benefits.

GUARANTEE OF PAYMENT: If my medical insurance coverage is not sufficient to satisfy the charges in full; I will be fully responsible for payment of the balance due upon discharge as consideration for medical services rendered. I agree to pay the established rates of Little Company of Mary Affiliated Services, Inc. for all services, facilities, equipment and supplies rendered. I also authorize Little Company of Mary Affiliated Services, Inc. to procure a credit bureau report to facilitate collection of any self-pay account balance and agree to pay same. In the event that it should become necessary to resort to outside collection procedures, Little Company of Mary Affiliated Services, Inc. reserves the right to charge patient its collection costs and reasonable attorney's fees. I will cooperate when applying for Financial Assistance, and agree to provide the necessary documents

MANAGED CARE PRECERTIFICATION, REFERRAL OR AUTHORIZATION OF SERVICES: I understand that my health plan may require a precertification, referral or authorization of services to be done by the member notifying their insurance plan before services are provided. Payment for services denied due to my failure to comply with the notification requirements of my insurance company will be my responsibility.

The undersigned certifies that he/she has read and understands the foregoing, and is the patient or is duly authorized to accept the above terms on the patient's behalf.

Signature

Date