

WOODBIDGE INTERNAL MEDICINE REGISTRATION FORM

Patient Information (Please Print)		Today's Date:
Last name:	First:	Middle:
Sex: <input type="checkbox"/> male <input type="checkbox"/> female	Birth date: / /	age:
Social Security No: - -	Marital Status: <input type="checkbox"/> single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	
Street address:		City, State, Zip:
Home Phone: Phone:	Work Phone:	Cell
Occupation:	Employer:	address:
Referred to office by:		
Pharmacy Name:		

INSURANCE INFORMATION (Please give your insurance card to the receptionist.)		
Please indicate primary insurance:		
Subscriber's name:	SSN:	DOB:
Group No: Deductible:\$	Policy No:	Co-payment:\$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> child <input type="checkbox"/> other		
Please indicate secondary insurance:		
Subscriber's name:	SSN:	DOB:
Group No: Deductible:\$	Policy No:	Co-payment:\$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> child <input type="checkbox"/> other		
EMERGENCY CONTACT: Name: Phone No:	Relationship:	

1. **AUTHORITY FOR TREATMENT:** I hereby authorize Woodbridge Internal Medicine, P.C and/or doctors in charge of the patient to administer such medication and to perform treatment that may be deemed necessary or advisable in the treatment of the patient.
2. **RELEASE OF INFORMATION:** I hereby authorize Woodbridge Internal Medicine, P.C to release any information pertaining to my health care, test results, billing and/or accounting information to Medicare or my insurance or Insurances Company. I also authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Woodbridge Internal Medicine PC and/or the doctor indicated on the claim.
3. Hereby I authorize Woodbridge Internal Medicine, P.C to release any medical information pertaining to my health care, test result to the following person(s) or agencies. Spouse Other
4. I understand I am financially responsible for any balance not covered by Medicare or my insurance company.

Patient/Guardian signature _____ Print name _____ Date _____

WOODBIDGE INTERNAL MEDICINE

Office policies:

- 1. Payments: Are expected when Services are rendered,** Payable by cash, check, or credit. We also do not accept any post dated checks. Any unpaid balance left from your insurance company, will be left for the responsible party to pay. All self pay Patients must pay by credit card or cash. For patients that have insurance, and will like to pay their co-pays with a check will be able to. If your check does come back bounced we will apply a fee of \$35 and we will no longer accept any checks from the responsible party. As of August1, 2009, all new patients must present a picture identification; if ID is not present we will not be able to keep your appointment.
- 2. Refills:** At the time of each visit we give you enough prescription refills until your next appointment. We also provide pharmacy request prescription refills by fax or phone. If you need refills you need to contact your pharmacy. If you miss your appointment we will not provide more than one month refill.
- 3. Missed appointment:** If you are not able to make your appointment, please let us know 48 hours before your appointment. If you miss more than 2 appointments we are not able to follow you as a patient.
- 4. Outstanding balance:** All outstanding balance after 90 days will turn to collection agency automatically. In this case you will be responsible for 35% more for collection fee and you will be responsible for all court and lawyer fees. We need credit card information to see a patient with an outstanding balance more than 60 days. If you need a payment plan please contact our office manager.
- 5. Referral:** Patients are responsible to make appointment for own referral; if you need help please let us know.

I agree with above office policies

Signature _____

Date_____

WOODBIDGE INTERNAL MEDICINE

Authorization to charge credit card:

I authorize Woodbridge Internal Medicine PC to charge my credit card for all copayment, deductible and all outstanding balance.

Name on credit card:

Credit card type: VISA Master card Discover American express

Card number _____

EXP. Date: ____/____ security number: _____

Signature: _____ Print name _____ Date _____