8.2-MTBC-F-07

CONFIDENTIAL

MEDICAL ONE, ACEC, INC

REGISTRATION INFORMATION
PLEASE PRINT

☐ New Patient
☐ Existing Patient
Existing Patient: Revise all information that has changed since your last visit

DATE ___/___/_____ **EMAIL ADDRESS** _____ **HOME PHONE:** (___) ___-____

PATIENT'S NAME: _____ , _____ _____
LAST FIRST MI

STREET ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

SSN: _____ - _____ - _____ **SEX:** ☐ M ☐ F **BIRTH-DATE:** ___/___/_____ ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

Patient Employed By: _____

Business Address: _____

Occupation: _____ Business Phone: _____

Name of Spouse/Responsible Party (If Patient is minor): _____
LAST FIRST MI

Spouse/Responsible Party Employed by: _____

Business Address: _____

Occupation: _____ Business Phone: _____

RESPONSIBLE PARTY/SPOUSE SSN : ___ - ___ - _____

DO YOU HAVE MEDICAL INSURANCE: ☐ NO ☐ YES **If Yes:**

NAME OF PRI. INS. : _____ **ID #:** _____ **GRP#:** _____

*** SUBSCRIBER'S NAME:** _____ ***BIRTH DATE:** ___/___/_____

ADDRESS OF PRI. INS. : _____

NAME OF SEC. INS. : _____ **ID #:** _____ **GRP#:** _____

*** SUBSCRIBER'S NAME:** _____ ***BIRTH DATE:** ___/___/_____

ADDRESS OF SEC INS. CO. : _____

***Required by HIPAA**

I prefer to:

☐ Pay my balance at the time of service ☐ Pay my balance upon receipt of first statement ☐ Make payment arrangement prior to rendering of services.

In case of emergency, who should be notified? _____ Phone: _____

ASSIGNMENT OF INSURANCE BENEFITS

The Medical One Registration form 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 agree to pay 1.5% per month interest on the unpaid balance of my account. I also agree that if this account is assigned to an attorney for collection and/or lawsuit, Medical One shall be entitled to reasonable attorney's fees and other costs of collection. I also authorize Medical One or insurance company to release any information required to process my claims.

_____ _____
Patient/Guardian Signatures Date