sansum CLINIC

MRN:_____
(Do Not affix label, print clearly)
Record Base #_____

PATIENT REGISTRATION

PATIENT INFORMATION

LEGAL NAME LAST, FIRST M.			CHART NO.	BILLING NO.	DATE
PATIENT ADDRESS	APT #		CITY	STATE	ZIP
HOME PHONE ( )			BUSINESS PHONE ( )	CELL PHONE ( )	
SEX	DOB	AGE	MARITAL STATUS	SOC SEC #	
PRIMARY CARE PHYSICIAN			E-MAIL		
EMPLOYER			OCCUPATION		
ADDRESS			CITY / STATE		ZIP

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY NAME LAST, FIRST M.			SOC SEC #	RELATIONSHIP
MAILING ADDRESS	APT #	CITY	STATE	ZIP
HOME PHONE ( )		BUSINESS PHONE ( )		
EMPLOYER		OCCUPATION		
ADDRESS		CITY / STATE		ZIP

PATIENT EMERGENCY INFORMATION

NAME			RELATIONSHIP
ADDRESS	APT #	CITY	STATE	ZIP
HOME PHONE ( )		BUSINESS PHONE ( )		

PLEASE CHECK THE NUMBER THAT BEST DESCRIBES YOUR RACE AND ETHNICITY

RACE:
- ☐ 1. American Indian / Alaska Native
- ☐ 2. Asian
- ☐ 3. Black or African American Native
- ☐ 4. Hawaiian / Other Pacific Islander
- ☐ 5. White or Caucasian
- ☐ 6. Other
- ☐ 7. Decline to provide
- ☐ 8. Unknown

ETHNICITY:
- ☐ 1. Hispanic / Latino
- ☐ 2. Non-Hispanic / Non-Latino
- ☐ 3. Other
- ☐ 4. Decline to provide

HOW DID YOU CHOOSE THE SANSUM CLINIC FOR YOUR VISIT TODAY? **PLEASE √ ONE OF THE FOLLOWING:**
- ☐ A. Insurance Provider
- ☐ B. Friend / Family
- ☐ C. Referred by outside M.D.
- ☐ D. Workers Comp / Employer
- ☐ E. Newspaper / Radio
- ☐ F. Yellow Pages
- ☐ G. Other_____

FINANCIAL POLICY

Thank you for choosing Sansum Clinic as your health care provider. We are committed to your treatment being successful. Please understand that the payment of your bill is considered a part of your treatment. The following is a statement of the Clinic's Financial Policy which requires your signature prior to treatment.

MINIMUM PAYMENT DUE AT EACH TIME OF SERVICE IS THE APPLICABLE DEPOSIT FOR SERVICES RENDERED TO THOSE PATIENTS THAT ARE UNINSURED. PATIENTS WITH NO INSURANCE: You will be asked for no less than the applicable DEPOSIT towards your bill at the time of each date of service. This will not be waived. The **DESIGNATED PAYMENT DOES NOT NECESSARILY CONSTITUTE THE TOTAL COST OF SERVICES ON THAT DATE.**

WE ACCEPT CASH, CHECKS, VISA, AND MASTERCARD.

SERVICE CHARGE: A $25.00 SERVICE CHARGE PER RETURNED CHECK WILL BE ASSESSED.

CO-PAYMENTS DEEMED YOUR RESPONSIBILITY BY YOUR INSURANCE CARRIER ARE DUE ON THE DATE OF SERVICE PRIOR TO SEEING THE PHYSICIAN.

REGARDING INSURANCE

HMO PATIENTS: (Assigned to Sansum Clinic): Co-payment is due at the time of service. This is a part of your insurance contract which will not be waived.

SANSUM CLINIC PARTICIPATING PPO PATIENTS: Annual unmet deductible, patient co-insurance and co-payments are due at the time of service. This is a part of your insurance contract which will not be waived. With an assignment of benefits on file and a copy of your PPO insurance card, we will bill the PPO carrier and extend the PPO discount to you. If services are non covered benefits and/or deductibles you will be responsible for payment in full upon receiving the explanation of benefits from your insurance carrier.

MEDICARE PATIENTS: You are responsible for the 20% deemed patient responsibility by Medicare. You are also responsible for non covered items and deductibles under the Medicare program. We do not bill Medicare supplemental policies.

PRIVATE PATIENTS: You will receive a monthly statement with all appropriate information to attach to your claim form and forward to your carrier. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance carrier does not pay within 60 days you will receive notice regarding your delinquent account. Please be aware that some and perhaps all of the services provided may be "non covered" services and not considered reasonable and necessary under your medical insurance.

You will be held responsible for payment on all services. **We do have a courtesy filling program and electronic billing** for patients with particular private insurances. Please ask the Registrar and/or the Private Patient Accounts Representative for further details. If your specific carrier does not participate in these programs, **you** will be responsible for filing to your carrier.

USUAL AND CUSTOMARY RATES

Sansum Clinic is committed to providing the best treatment possible for our patients and we charge what is usual and customary for the area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates. Fees are subject to change without prior notification.

Thank you for reading and understanding the Clinic's Financial Policy. Please let us know if you have any questions or concerns.

AUTHORIZATION TO RELEASE INFORMATION: I understand that Sansum Clinic will maintain records of my contacts for services and in general no information will be released without my specific written consent. I am aware, however, that information concerning my treatment and services rendered may be released as necessary to receive reimbursement by public and private health insurance plans. I authorize Sansum Clinic to release any medical/psychiatric/substance dependency information necessary for the processing of claims. I permit a copy of this authorization to be used in place of the original. I request that payment under my medical insurance be made directly to Sansum Clinic. I understand I am responsible for charges not paid by my insurance carrier.

I HAVE READ THE FINANCIAL POLICY (ABOVE). I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

X _____ _____ Date: _____

Signature Responsible Party — Name of Responsible Party (Print)

_____ _____

Patient Name — Medical Record #