MOUNTAINVIEW FAMILY PRACTICE

741 NE 6th Street
Grants Pass, OR 97526
(541) 471-2701
Fax (541) 471-1166
www.mvfp.com

Date_____

Patient Registration (please print)

Patient information

Last name_____First name_____Middle name_____

Mailing address_____Home phone_____

Street address_____Cell phone_____

City_____State_____Zip_____

Best number to reach you at_____Okay to leave a message?_____

Social security number_____Date of Birth_____Age_____Sex_____

Marital status_____Email address_____

Employer info.

Patient occupation_____

Patient employer_____

Employer's address_____

Employer's phone_____

Full time_____Part time____Retired_____Student____

Name of School_____

Spouse_____Phone_____

Spouse address_____

Spouse's social security number_____

Spouse's date of birth_____

Spouse's occupation_____

Spouse's employer and address_____

Responsible party info.

Responsible party_____Date of birth_____Social security number_____

Address_____Phone number_____

Relationship to patient_____Occupation_____

Work address_____Work phone_____

Insurance information

Primary insurance company name

_____

Address_____

_____

Phone number_____

Group number_____

ID number_____

Policyholder's name_____

Secondary insurance company name

_____

Address_____

_____

Phone number_____

Group number_____

ID number_____

Policyholder's name_____

Is your condition related to employment or an auto accident_____

Current or previous_____Date of injury_____

Which state_____Brief description of injury_____

Emergency information

Emergency contact (a person not living with patient)

Name_____Relationship to patient_____

Address_____Phone_____

City_____State_____Zip_____

(Please complete information on reverse)

Patient Registration (continued)

Patient name_____Date_____

It is the office policy to inform you of our patient payment procedure. Please review the section below that is applicable to you.

_____**1. Patient With Insurance**

You will be asked to present your insurance card at each visit. If you do not have all the necessary information with you, you will be billed directly until you are able to provide all of the required information. You are responsible for deductibles, copays, non-covered services, coinsurance and items considered “not medically necessary” by your insurance company. Please pay co-payments and coinsurance amounts as services are rendered. The remaining balance should be taken care of within one (I) month of notice from insurance company. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, notify the front desk staff to make other arrangements.

_____**2. Parent/Child**

The adult accompanying the child is responsible for payment at the time of service including co-payment. The parent/guardian with whom the child resides is the person who will be billed for services rendered. We will not be involved in mediating financial arrangements between parents/guardians. We will bill insurance as stated above.

_____**3. Medicare**

Our office will submit your Medicare charges to Medicare and your secondary Insurance. You are responsible for deductibles, copays, and any non-covered services.

_____**4. Worker’s Compensation Patient**

As a Worker’s Compensation patient you may be covered by insurance if your injury is reported at work and verified with your employer. Be sure to inform the office personnel that your injury resulted during employment. Patient is ultimately responsible for the balance.

_____**5. Personal Injury (Accident)**

If you are a personal-injury patient, our office will bill the appropriate insurance company. If we are unable to obtain payment, the charges for the services rendered will be your responsibility. Please give all information needed for billing.

Assignment

_____I request that payment of authorized Medicare benefits be made either to me or on my behalf to Mountainview Family Practice for any service provided to me by that provider.

_____The signature below authorizes payment of mandated Medicare benefits to Mountainview Family Practice.
Medigap_____Policy number_____Group number_____

_____I assign the benefits from my insurance carrier(s) to this clinic for the medical/surgical benefits I am entitled to.

I have read and agree to the Financial Policy and Assignment paragraphs stated above that apply to me.

Patient / responsible party signature_____Date_____

Person signing on behalf of patient (print name)_____Reason patient cannot sign_____

Relationship to patient_____Address_____Phone_____