EISENSTEIN CLINIC

REGISTRATION FORM

(Please Print)

Today's date:					
PATIENT INFORMATION					
Patient's last name: First: Middle:			Birth Date: / /	Age	Sex:
Street address:		Cell phone no:			Home phone no.:
City:	State:		Zip Code:		E-Mail:
Other family members seen here:					

Best way to reach you for appointment reminders: _____ (If phone call, please make sure voicemail is not full)

INSURANCE INFORMATION					
(Please give your insurance card to the front desk.)					
Primary Insurance Holder Name:	Birth date: / /	Address (if different):		Home phone no.: ( )	
Is this patient covered by insurance? ❑ Yes ❑ No					
Primary Insurance:	Insurance Group #	Insurance Policy #	Co-Payment $		
Patient's relationship to primary holder: ❑ Self ❑ Spouse ❑ Child ❑ Other					

The above 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 also authorize Eisenstein Clinic or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our policies, which we require you read and agree to prior to any treatment.

APPOINTMENTS

Arrival

- Please arrive 10 minutes prior to your appointment to check-in. If you are more than 15 minutes late from your scheduled appointment time, you will not be able to be seen at that time and will have to reschedule.

Missed Appointments

- We require 24-hour notice for any appointment that you are unable to attend. Any missed appointments will be charged a $25.00 no show fee.
- If your child misses 3 appointments without notifying our office in advance, your child will be discharged from the practice.

Patient Forms

- Please give our office up to 1 full business week to complete any forms, letters, or prescriptions you may need filled out and signed by the physician.
- There is a $10.00 fee for all forms not presented to the staff at the appointment. This $10.00 fee must be paid at the time the form is dropped off at our office. There will be a $20.00 fee for any form needed the same day it is dropped off to the office. We will not mail/fax/scan/e-mail any forms. They must be dropped off and picked up.

INSURANCE

- It is patient responsibility to know insurance benefits, including whether we are a contracted provider, your covered benefits, any exclusions, and any pre-authorization requirements of your insurance company.
- You must bring your current insurance card with you for each visit and for each patient. It is your responsibility to notify our staff of any insurance information changes.

Co-Payments

- Your co-pay is due at the time of your visit.

Self-Pay Patients

- If you do not have insurance to cover the cost of the visit, you must pay in full at the time of the appointment.

BILLING

- At the time of the visit, we will need a card on file for any delayed billing. If we have a contract with your insurance company we will bill your insurance company first and then use the card on file for anything not covered. It is patient responsibility to review the EOB (explanation of benefits) for anything not covered.

Late Payment Fees

- A fee of $20 will be assessed on accounts that are 60 days past due. An additional fee of $50 will be charged to accounts that are 90 days or more past due.

Any account balances over 90 days old will receive a letter and will need to be settled in 10 days. If payment is not received or arrangements made, we will assume you no longer want to have your children seen at the Eisenstein Clinic. Your account will be sent to collection, and all legal fees and collection expenses will be added to your balance. By law, we will continue to provide emergency care for 30 days from the date of notice. Should a patient need non-emergent medical attention in those 30 days, you will be required to settle your account prior to the visit.

I have read the policies contained above, and my signature below serves as acknowledgement of a clear understanding of my responsibilities. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient