Cottonwood Clinic, LLC Patient Registration Form

PATIENT INFORMATION

(Please Print)

Patient's Name (Last)_____ (First)_____(MI)_____

Also Known As Name (Last)_____(First)_____

Date of Birth _____/_____/_____ ☐Female ☐Male Social Security Number_____-_____-_____

Phone Numbers Home_____Cell_____Work_____

Mailing Address_____ City, State, ZIP (+4) _____

Physical Address (if different from mailing)_____

Email Address: _____

Preferred Method of Contact: Home phone Cell Phone Work Phone eMail Work eMail OK to leave message ? Yes No

Marital Status ☐Married ☐Single ☐Divorced ☐Widowed ☐Legally Separated ☐Other

Race ☐White/Caucasian ☐Asian ☐Native Hawaiian or other Pacific Island ☐Black/African American ☐American Indian/Alaska Native

Ethnicity ☐Not Hispanic or Latino ☐Hispanic or Latino Preferred Language:_____

Employment Status ☐Employed ☐Full-Time Student ☐Part-Time Student ☐Retired ☐Self-Employed ☐Unemployed

Employer_____

Occupation: _____

Emergency Contact Name: _____ Phone: _____

List the names of your child's Parents/Guardians below

Name:_____Relationship_____

Name:_____Relationship:_____

RESPONSIBLE PARTY INFORMATION ***Statements will be addressed to the Responsible Party***

Responsible Party Name (Last)_____ (First)_____ (MI)_____

Date of Birth _____/_____/_____ ☐Female ☐Male Social Security Number _____-_____-_____

Phone Numbers Home_____Cell_____ Work_____

Address_____ City, State, ZIP: _____

Employment Status ☐Employed ☐Full-Time Student ☐Part-Time Student ☐Retired ☐Self-Employed ☐Unemployed

Employer_____ Employer Phone Number_____

Primary Insurance Information **(please provide your insurance card to the front desk at check-in)**

Insurance Plan Name: _____

Subscriber Name: _____ Subscriber Relationship to Patient: _____

Subscriber Date of Birth: _____/_____/_____ Subscriber Social Security Number: _____-_____-_____

Insurance Address: _____Insurance Phone: _____

Secondary Insurance Information **(please provide your insurance card to the front desk at check-in)**

Insurance Plan Name: _____

Subscriber Name: _____ Subscriber Relationship to Patient: _____

Subscriber Date of Birth: _____/_____/_____ Subscriber Social Security Number: _____-_____-_____

Insurance Address: _____Insurance Phone:_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

I consent to the treatment rendered by the providers, nurses, staff, and assistants at Cottonwood Clinic, LLC that is deemed necessary to my health. This may include but is not limited to evaluation, lab draws, lab tests, imaging, minor procedures, and additional testing.

I fully understand that I am responsible for the charges incurred with each visit and although my insurance may be billed, I am ultimately responsible for payment as outline in the financial policy.

I have received a copy of the clinic Privacy/HIPAA policy.

Would you like to be given access to our online patient portal? YES NO

Patient (or Responsible Party) Signature_____ Date_____

COTTONWOOD CLINIC, LLC

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Cottonwood Clinic's Notice of Privacy Practices effective April 21, 2014.

Name (please print): _____

Signature: _____

Date: _____

I am a parent or legal guardian of (patient name) _____. I have received a copy of Cottonwood Clinic's Notice of Privacy Practices effective April 21, 2014.

Name (please print): _____

Relationship to Patient: _____ Parent _____ Legal Guardian

Signature: _____

Date: _____

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgement could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective April 21, 2014 given to individual on _____(date)

_____ In Person _____ Mailing _____ Email _____ Other _____

Reason individual or parent/legal guardian did not sign this form:

_____ Did not want to

_____ Did not respond after more than one attempt

_____ Other _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome as applicable, and the efforts that were made to obtain the signature. More than one attempt must be made.

_____ In person conversation _____

_____ Telephone contact _____

_____ Mailing _____

_____ Email _____

_____ Other _____

Staff Name (please print): _____ Title: _____

Signature: _____ Date: _____

PATIENT FINANCIAL POLICY

It is the goal of Cottonwood Clinic, LLC to provide the best care on your behalf. It is also our desire to assist you in the financial arrangements related to this care. Therefore, it is important for you to fully understand our insurance, credit, and collection policies. Please read the following information carefully and feel free to ask any questions you may have in any area. We ask that you sign this statement when you have read and understand each point covered.

Upon registration each patient is asked to complete our Patient Information form, a Patient Health History, and an Account Balance Agreement. A copy of your primary and secondary insurance cards will be requested for verification of insurance coverage and benefits.

Payment for the patient portion is due at the time of service. If unusual circumstances should make it impossible for you to meet these terms, we invite you to discuss with our office options available to you. We will work with you to arrive at a mutually agreeable payment plan.

If you have health insurance, it should be understood that this is an agreement between you and your insurance carrier to pay for medical care. Our office will file your insurance claims for you. We hope that this will alleviate part of the burden of necessary paperwork. Your bill is an agreement between you and this office. You are ultimately responsible for the payment of your bill regardless of the status of your insurance claim. The only exception in the above policy applies to those patients who are covered by an insurance company that our office has contracted with to provide services within their fee schedule. These contracts are subject to change with or without notice. ***All co pays are due at the time of service.***

You will receive regular statements (every 25 days) from our office informing you of the status of your account. Feel free to call our office should you have any questions. A $5.00 late charge may be assessed on any balance over 90 days past due. If we have not received any payment from you within 120 days from the date of service, we reserve the right to refer your account balance to an outside collection agency where you will be responsible for all collection and legal fees. There will be an $18.00 fee for all checks presented for payment with non-sufficient funds. You will also be billed separately by the hospital or other sources, if it applies, for certain lab fees, radiology fees, and/or outpatient or inpatient services.

ACCOUNT BALANCE AGREEMENT – PATIENTS WITH INSURANCE

Please initial the option you prefer and provide signature.

- (Initials) _____ I will make full payment at the time of service.
- (Initials) _____ I will make monthly payments toward my balance due.

Account Balance	Minimum Payment Due
Under $150	$50/month
$151-$299	$75/month
$300-$499	$100/month
$500-$999	$250/month
$1,000 +	$500/month

ACCOUNT BALANCE AGREEMENT – PATIENTS WITHOUT INSURANCE

We typically do not carry balance unless prior arrangements have been made.
Balance is due at time of service. 10% discount will be applied.

I have read and understand the above financial policy and account balance agreement. I understand that if I should default on this agreement and my account is turned over for third party collection that I will be liable for court costs, attorney fees, or any other collection costs resulting from this default, in addition to my account balance.

Signature: _____ **Date:** _____