**METROPOLITAN FAMILY CARE, INC.** Today’s Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

**REGISTRATION FORM**

(Please PRINT)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s Last Name: | | | | | | | First: | | | | | | | | | | | Middle: | | | | | | | | * Mr. * Dr. | | | | | | | * Mrs. * Miss. | | | | * Sr. * Jr. |
| Street Address | | | | | | | | | | | | | | | | | | | City | | | | | | | | | | | | | State | | | | Zip Code | |
| Home Phone #: | | | | | | | Work/Cell Phone #: | | | | | | | | | | | | | E-mail Address: | | | | | | | | | | | | | | | | | |
| **Birth Date** | | | **Age** | | | | | | | **Social Security Number** | | | | | | | | | | | | | | | **Marital Status** | | | | | | | | | **Sex** | | | |
| **/ /** | | |  | | | | | | |  | | | | | | | | | | | | | | | * Single * Widowed * Married * Divorced | | | | | | | | | * Male * Female | | | |
| **INSURANCE INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Occupation: | | | | | | | | | | | | | Insured Employer | | | | | | | | | | | | | | | | | | | | | | | | |
| Insured Employer Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Please Indicate Primary Insurance** | | | | | | | Address of Primary Insurance Carrier | | | | | | | | | | | | | | | | | | | | | | | | Phone Number | | | | | | |
| Insured Name | | | | | Insured SSN # | | | | | | | | | | Insured ID # | | | | | | | | Policy Group # | | | | | | | | Effective Date | | | | | Co-Payment $ | |
| Patient’s Relationship to Insured | | | | | | | | * Self | | | | | | * Spouse | | | | | | | | * Child | | | | | | * Other | | | | | | | Insured Birth Date | | |
| Insurance Type | | * PPO * HMO | | | | * EPO * POS | | | | | | * Self-Pay * Medicare | | | | | | | | | * Public Aid * WC | | | | | | | | * OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| Please Indicate Secondary Insurance | | | | | | Address of Secondary Insurance | | | | | | | | | | | | | | | | | | | | | | | | Phone Number: | | | | | | | |
| Insured Name | | | | | Insured SSN # | | | | | | | | | | Insured ID # | | | | | | | | Policy Group # | | | | | | | | Effective Date | | | | | Co-Payment $ | |
| Patient’s Relationship to Insured | | | | | * Self | | | | | | * Spouse | | | | | | | * Child | | | | | | * Other | | | | | | | | | Insured Birth Date | | | | |
| **DEMOGRAPHCS (FOR GOVERNMENTAL STATISTICAL ANALYSIS)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Race: | * American Indian/ Alaska Native * White | | | | | | | | * Asian * Hispanic | | | | | | | * Native Hawaiian * Other Pacific Islander | | | | | | | | | | | * Black or African American * I Decline to Report | | | | | | | | | | |
| Ethnicity: | * Hispanic | | | | * Non-Hispanic | | | | | | | | | | | | * I Decline to Report | | | | | | | | | | | | | | | | | | | | |
| Preferred  Language: | * English | | | * Spanish | | | | | | | | | | | * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | |

**AUTHORIZATION FOR ASSIGNMENT X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OF BENEFITS** Signature Date

**HIPAA AUTHORIZATION X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature Date

Metropolitan Family Care, Inc.

3341 East Livingston Avenue, Suite D

Columbus, Ohio 43227

Phone: (614) 237-1067 Fax: (614) 237-2655

**Our Financial Policy**

*We are dedicated to providing the best possible care for you. We want you to completely understand our financial policies.*

1. We accept cash, check, debit or credit cards with the Visa or MasterCard logo and Discover Card. If you come to your appointment without the proper insurance cards, necessary identification or your co-payment you will be rescheduled. Any payments made by phone will be charged an additional $1.50 to process your payment.
2. We have made prior arrangements with many insurance companies to accept an assignment of benefits. You are required to pay your co-payment at the time of your visit. We will bill your carrier.
3. Please keep in mind that your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor- in other words; you agree to have your insurance company pay the doctor directly. If you insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment to you directly. Therefore, our charges for your care are due at the time of service.
5. Not all insurance plans cover all services. In the even your insurance plan determines a service to be “not covered”, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
6. We will bill your insurance company for all physician services provided in the hospital or office. You are responsible for any balance due.
7. Because of the limited time offered by your insurance to file a claim if no payment is received from your carrier within seventy (70) days from your date of service you will be financially responsible for the entire payment.
8. Any unpaid account(s) will be referred to an outside collection agency. Should further litigation become necessary, you will be assessed the attorney’s fee in order to resolve your debt.

*I have read and understand the financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice as deemed necessary by the management.*

|  |  |
| --- | --- |
|  |  |
| Signature of Patient (or responsible party, if minor) | Date |
|  | |
| Please Print the Name of the Patient. |  |

Metropolitan Family Care, Inc.

3341 East Livingston Avenue, Suite D

Columbus, Ohio 43227

Phone: (614) 237-1067 Fax: (614) 237-2655

**CONSENT AND RELEASE OF INFORMATION**

**2014**

**MEDICARE PATIENTS**

I authorize any hold of medical or other information about me to release to the Social Security Administration or its intermediaries or carries any information needed for this or related Medicare Claim. I permit a copy of this information to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment of this date of treatment.

**CONSENT TO TREATMENT AND RELEASE OF RESPONSIBILTY AND INFORMATION**

I (we) hereby consent and authorize the medical and/or surgical treatment, which is considered necessary or advisable in the judgment of the physician(s) while in Metropolitan Family Care, Inc. facilities. If I (we) refuse treatment or leave the medical practice contrary to the judgment of the physician(s), I (we) release the physician(s) of responsibility for the results of my action.

**I (WE) AM RESPONSIBLE FOR THE PAYMENT OF THIS TREATMENT**

I (we) authorize any approved medical insurance, which I have to make payment directly to the Metropolitan Family Care, Inc. and/or the physician. I (we) will pay any balance not covered by the approved medical insurance.

I (we) authorize the release of the medical practice records with information involving the medical treatment to the medical insurance carrier and family physician.

Signature (Patient/Guarantor)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (Witness)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Metropolitan Family Care, Inc.

3341 East Livingston Avenue, Suite D

Columbus, Ohio 43227

Phone: (614) 237-1067 Fax: (614) 237-2655

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS**

**2014**

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your healthcare provider or staff of Metropolitan Family Care, Inc. to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

* I understand that I have the right to revoke this authorization in writing at any time.
* I understand that it is **MY RESPONSIBILITY** to make Metropolitan Family Care, Inc. aware of any changes to this consent.
* I understand that certain information cannot be release without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

\_\_\_\_\_ Information regarding the patient’s diagnosis and treatment of HIV/AIDS

\_\_\_\_\_ Psychotherapy notes from a Psychiatrist or Psychotherapist.

\_\_\_\_\_ Treatment for alcohol or drug abuse reports.

\_\_\_\_\_ **I DO NOT AUTHORIZE** Metropolitan Family Care, Inc. to release any or all information concerning my medical care to any individual except as set forth above.

\_\_\_\_\_ **I AUTHORIZE** Metropolitan Family Care, Inc. to verbally release any or all information concerning my medical care to the following individuals.

|  |
| --- |
| Name/Relationship to Patient |
| Name/Relationship to Patient |
| Name/Relationship to Patient |
| Name/Relationship to Patient |
| Patient Signature Date |