Patient Registration Forms

Patient Name:		**DOB:**	**Sex:**
Marital Status:	**Social Security:**	**Email:**	
Address:		**City/State/Zip:**	
Home Phone:	**Work:**	**Cell:**	
Primary Care:		**Telephone:**	
Pharmacy:		**Telephone:**	
Emergency Contact:	**Relationship:**	**Telephone:**	

Insurance Information

Primary Insurance:	**ID:**	**Group#:**
Telephone:	**Telephone:**	
Secondary Insurance:	**ID:**	**Group#:**
Telephone:	**Telephone:**	

I herby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to including Medicare, Medigap, Preivate insurance and other health insurance plants to Dr. Patricia T. Hopkins.

The assignment will remain in effect until revoked in writing. A photocopy of this statement is to be considered as valid as an original. I understand that I am financially responsible for all charges weather or not paid by said assignees to release all information necessary to secure that payment.

Signature: _____ Date: _____

Name Printed: _____

Past Medical History

Please check the boxes if any apply:

	Migraines/Headaches		Asthma		Seizures		Fibromyalgia		Hernia
	High Blood Pressure		Diabetes		Glaucoma		Muscle Disorder		Gout
	Emphysema/Lung disease		Bipolar		Cataracts		Pneumonia		Depression
	Bladder Problems		Anemia		Stroke		Gallstones		Cancer
	Bleeding Problems		Angina				Thyroid Disease		Kidney Stones
	Neurological Disorders		Fevers		Cardiovascular Diseases		Stomach Ulcers		
	Irregular Heart Beats		TB		Blood Clots		Kidney Disease		
Other Health Problems:									

Please list any operations you have has in the past:

1.

2.

3.

4.

5.

6.

Social History

	Yes	No		Yes	No
Tobacco			**Lives Alone**		
Alcohol			**Seat Belt Use**		
Drugs			**Employed**		
Exercise			**Sexually Active**		
Children			**Pets**		
Caffeine			**Motility Devices**		

Family History

Grandfather	
Grandmother	
Father	
Mother	
Sibling	
Sibling	

Other pertinent information:

Patient Name: **DOB:** **Date:**

Reason for visit:
Sign/symptoms you are experiencing:
Please ALL current medication/doses and supplements you are taking:
List any allergies:
List any physician names, radiology/laboratory testing or hospitalizations that you feel would be important to review for this appointment.
Are you having any pain today? **If so scale 0-10 what is your pain level today:** **Location of the pain:** **Description:**
Please write any questions you might have for the provider today?

Patient Payment Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

INSURANCE

We participate in most managed care plans and will bill your insurance plan as may be necessary. If we do not participate with your managed care plan, payment in full is required at the time of service, unless other arrangements have been made in advance. We may be able to bill your plan as a courtesy to you and credit your account if we receive any additional payment. Knowing your insurance benefits – including eligibility, covered benefits, and medically necessary procedures, is your responsibility; please contact customer services at your insurance company for questions you may have regarding your coverage. **You are responsible for any charges not covered by your plan**.

Proof of Insurance

All patients must complete and/or update our Patient Information Form at each office visit. You must furnish valid and up-to-date proof of insurance coverage and a copy of your driver's license. If you provide false or expired insurance information you will be responsible for the balance of the claim. Please notify us of any changes in insurance coverage prior to time of service. Insurance denials for termination of coverage will be automatically billed to you.

Co-payments and Deductibles

All co-payments and unsatisfied deductibles must be paid at the time of service. By contractual law your insurance company requires us to charge for, and you to pay for, all required co-payments, co-insurances, deductible and non-covered services.

Claim submission

We will submit your insurance claims and assist you in any way reasonable to help get your claim paid. Your insurance company may need you to supply information directly to them. It is your responsibility to comply with their request in a timely manner. Please be aware that the balance of your claim is your responsibility to pay whether or not your insurance company has paid. We are not a party to your insurance contract.

Referrals

If you have an **HMO** plan with which we are contracted, you **NEED** a referral authorization from your primary care physician. If we have not received an authorization prior to your appointment we ask you call your primary care physician to obtain it. **If you are unable to obtain the referral at that time, you will be rescheduled or responsible for payment.**

How May I Pay?
We accept payment by cash, check, VISA, MasterCard, American Express, Discover and etc.

Which Plans Do We Contract with?
We are contracted with mostly all commercial insurances. Medicare, Medicaid, AARP, Tufts Medicare Preferred, Harvard Pilgrim Enhanced, Neighborhood Health, Tufts Network Health and Blue Cross Blue Shield Medex we are only listed as a Specialist. It is always a good idea to call your plan before your appointment just to double check with your insurance.

I have read, understand, and agree to the above Financial policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to Dr. Patricia Hopkins practice.

I authorize Dr. Patricia Hopkins to release pertinent medical information to my insurance company when requested, or to facilitate payment of claim.

_____	_____	_____
Patient Name (Printed)	Patient Signature	Date