Today's Date:

PATIENTS ARE REQUIRED TO FILL OUT ALL FIELDS

PATIENT INFORMATION: (Please use full legal name, no nicknames)

Last Name:_____ First Name:_____ MI:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone#: (_____) _____ - _____ Social Security Number:_____

Date of Birth:_____ Age:_____ Sex: M F Marital Status:_____ Drivers Lic#: _____

Race:_____ Ethnicity: _____ Language: _____

Employer Name and Address:_____

Work Phone# :(_____) _____ - _____ Occupation: _____

Cell Phone#:(_____) _____ E-mail Address:_____

Emergency Contact Name/Relationship/Phone#: _____

Primary Care Doctor: **Referred by:**

GUARANTOR / RESPONSIBLE PARTY INFORMATION: *(List person or insured name responsible for bill – use full legal name, no nicknames.* ***OR*** *Complete if patient is 17 or younger. Any legal guardian/parent presenting a minor patient for medical services is considered financially responsible for services rendered. Any minor patient accompanied by an adult other than their legal guardian/parent must present written and notarized authorization for medical treatment from the legal guardian/parent prior to services being rendered.)*

Relationship of Guarantor to Patient: Self Spouse Parent Other:_____

Last Name:_____ First Name:_____ MI:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone#: (_____) _____ - _____ Social Security #:_____

Date of Birth:_____ Age:_____ Sex: M F

INSURANCE INFORMATION: *(Your insurance card may have been scanned, however, in order to process your claim correctly; we need to have COMPLETE and accurate information. Please complete the section(s) below.)*

PRIMARY INSURANCE:

Plan Name:_____ Insured's Name:_____

Insured's Social Security #:_____ Insured's Date of Birth:_____

Policy / ID #: _____ Group #:_____ Effective Date:_____

Claims Address & Phone:_____

SECONDARY INSURANCE:

Plan Name:_____ Insured's Name:_____

Insured's Social Security #:_____ Insured's Date of Birth:_____

Policy / ID #: _____ Group #:_____ Effective Date:_____

Claims Address & Phone:_____

WAS YOUR INJURY A RESULT OF A CAR ACCIDENT OR WORK RELATED? □ No □ Yes:_____

DESCRIBE HOW THE INJURY OCCURRED: _____

_____

WORKER'S COMPENSATION:

Claim Number:_____ Date of Injury:_____

Insurance Carrier:_____ Adjuster's Name & Phone #:_____

Insurance Carrier Address:_____

Name of Nurse Case Manager:_____ Phone Number:_____

Do you have an attorney? Yes □ No □ If so who? _____

PATIENT REGISTRATION FORM DISCLOSURES & CONSENTS

Patient Name: _____ Date of Birth: _____.

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to Joseph C. Cheng, M.D. for services rendered to me or my dependents. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance that Joseph C. Cheng, M.D. is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependents records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Joseph C. Cheng, M.D.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received and read a copy of the Joseph C. Cheng, M.D. Patient Information Privacy Policy. I hereby authorize Joseph C. Cheng, M.D. to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL, OR E-MAIL:
I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Joseph C. Cheng, M.D. representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, and referral arrangements. I understand that I have the right to rescind this authorization at any time by notifying Joseph C. Cheng, M.D. to that effect in writing.

NO SHOW POLICY:
I am aware and understand the "No Show" policy. I must advise the office at least 24 hours in advance if I need to reschedule. If no notice is given to office, I am aware that I will be charged a fee of $30. If I miss 2 appointments without notice (not consecutive), I will be formally discharged from the practice.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by Joseph C. Cheng, M.D. or his designee.

PATIENT SIGNATURE: _____ **DATE:** _____.

GUARANTOR SIGNATURE: _____ **DATE:** _____.
(If different from patient)

GUARANTOR NAME (Please Print): _____.

FINANCIAL RESPONSIBILITY AGREEMENT

I understand and agree it is my responsibility and not the responsibility of the Physician or Clinic to know if my insurance will pay for my Medical service or visit, Lab testing, X-ray, EKG, or any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility to know if my insurance has any Deductible, Co-payment, Co-insurance, Out-of-Network amount, Usual and Customary Limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

SIGNATURE: _____ **DATE:** _____.
(please sign here- Patient or Responsible Party)

RESPONSIBLE PARTY NAME: _____.
(please print name of Responsible Party if different from Patient)