

## REGISTRATION INFORMATION

Today's Date:

Primary Care Physician:

### PATIENT INFORMATION

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle name: \_\_\_\_\_  
 Mr.  Miss  Marital status: \_\_\_\_\_  
 Mrs.  Ms.  S  M  D  SEP  W

Is this your legal name? Yes  No  If not, what is your legal name? \_\_\_\_\_  
 Former name (if applicable): \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
 M  F

SS#: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Other means to contact you: \_\_\_\_\_

Street Address / P.O. box: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Why did you choose us for your healthcare needs? (check one): Referred by Dr.  Insurance  Hospital  Family  Friend   
 Location  Yellow Pages  Ad  If so, where? \_\_\_\_\_ Other

Other family members seen here:

### INSURANCE INFORMATION

(Please give your insurance card and photo ID to the person at the front desk)

Person responsible for bill: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Address (if different): \_\_\_\_\_ Home Phone: \_\_\_\_\_

Is this person a patient here? Yes  No

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer address: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Is this patient covered by insurance? Yes  No

Primary Insurance:

ID Number:

Subscriber name: \_\_\_\_\_ Subscriber SS#: \_\_\_\_\_ Birth date: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Co-payment: \_\_\_\_\_  
 \$

Patient's relationship to subscriber: Self  Spouse  Child  Other

Secondary Insurance (if applicable): \_\_\_\_\_ Subscriber's Name: \_\_\_\_\_ ID or Policy#: \_\_\_\_\_ Group #: \_\_\_\_\_

Patient's relationship to subscriber: Self  Spouse  Child  Other

**AUTO INJURY / WORK INJURY / PERSONAL INJURY INFORMATION**

Insurance Type: Auto <input type="checkbox"/> Work Injury <input type="checkbox"/> Private <input type="checkbox"/> Lien <input type="checkbox"/>			
Patient's relationship to Insured: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			
Date of Injury:	Describe how injury happened:		
Insurance Company:	Phone:		
Address:	City:	State:	ZIP Code:
Policy #:	Claim #:	Workers Comp #:	
Did you report the injury? Yes <input type="checkbox"/> No <input type="checkbox"/> To Whom:			
Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>	Where?	X-Rays taken? Yes <input type="checkbox"/> No <input type="checkbox"/>	Where?
Were you working at the time of the accident? Yes <input type="checkbox"/> No <input type="checkbox"/>		Dates lost from work:	
Doctors seen for this injury:			
If auto injury, were you: Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other: <input type="checkbox"/>			
# of people in your vehicle:	Seatbelt worn: Yes <input type="checkbox"/> NO <input type="checkbox"/>	Airbag inflated: Yes <input type="checkbox"/> No <input type="checkbox"/>	

**IN CASE OF EMERGENCY**

Name of local friend or relative (not living at your address):	Relationship:	Home Phone:	Work Phone:
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## PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing The Knight Center for Integrated Health for your healthcare needs. As a patient, it is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance or co-payment amounts prior to any visit. Not all services are covered in all insurance contracts. As a result, some procedures we feel are medically necessary for optimal treatment or preventative care may not be covered by some plans. Due to the differences in various insurance plans and programs, we cannot guarantee that services provided by our practice will be covered under your insurance policy. In addition, our practice may not have a preferred provider agreement with your insurance company. If your insurance plan does not cover a service or procedure, you are responsible for payment of these charges. It is your sole responsibility to know and determine what medical procedures your policy includes and excludes including specialists, hospitals, lab tests, x-ray facilities and other medical facilities that are accepted and covered by your insurance plan. To find out what your insurance plan covers and what your financial obligation may be, call the member services department listed on your insurance card. Your employer's human resources department may also be a source of information and assistance.

For the convenience of our patients we accept cash, Visa, Master Card, Discover, traveler's checks, Money Orders and personal checks. Co-payments, co-insurance and deductibles required by individual insurance plans are due at the time services are rendered. We also welcome self-paying patients when insurance coverage is not available for our services. Patients without insurance are expected to assume full financial responsibility for all medical services provided. If, for any reason, full payment cannot be made at the time of service, please contact our office to determine if a reasonable payment arrangement can be established.

In order to be respectful of the medical needs of others we require a 24 hour advance notice of any cancellations. Failure to comply may result in a cancellation fee.

We accept Medicare assignment of covered charges. Patients will be billed for co-insurance, annual deductibles or any uncovered charges unless the patient has supplemental insurance.

Workman's Compensation cases require prior authorization from either the employer or insurance carrier agent before treatment. Should the employer or carrier subsequently deny validated worker's compensation service, such charges will become the financial responsibility for the patient and subject to the terms and conditions outlined in the preceding paragraphs.

In cases of personal injury, we do not defer payment until settlement or judgment. Any patient treated in relation to a personal injury case will be expected to assume full financial responsibility under the terms and conditions outlined in the preceding paragraphs. Claims will be submitted to your insurance company and you will be charged the usual co-payments, co-insurance and deductibles. It will be your responsibility to seek personal reimbursement from the sources you feel are responsible. In the case where your health insurance company denies such claims you will be responsible.

### RELEASE

I have read the policy regarding my financial responsibility to Knight Medical & Rehab Center, Ltd and Dr. Rebecca A. Knight. I hereby certify that all information I have provided is accurate and true. I authorize payment of any benefits directly to Knight Medical and Rehab Center, Ltd. for all services rendered. In the event that my health plan determines services as not covered, I will be responsible for the all charges. I agree to be responsible for payment of all unpaid services rendered on my behalf or behalf of the above named patients including any collection fees, attorney's fees or court costs incurred through efforts to collect payment for such charges.

I request that payment of authorized Medicare benefits, if applicable, be made on my behalf to Knight Medical & Rehab Center, Ltd. for services rendered to me by my provider. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

*Patient/Guardian signature*

*Date*