

Please Print or Type

THE EMORY CLINIC REGISTRATION INFORMATION

| |
|---------------------------|
| Emory Clinic Chart Number |
| Emory Clinic Doctor |
| Appointment Date |

Patient Information:

| | | | | | |
|-------------------|-----------------------|-------|---------------|------------------------|----------------|
| Patient Name | Last | First | Middle | Social Security Number | Occupation |
| Maiden Name | Last | First | Middle | Employer | |
| Address | Street | | Apt. | Street | |
| | City | State | Zip | City | State Zip |
| Home Phone () | Business Phone () | | Date of Birth | Sex | Marital Status |

Person Responsible for Bill (Omit if Same as Patient Information):

| | | | | |
|-------------------|-----------------------|--------|--------------|------------------------|
| Last | First | Middle | Relationship | Social Security Number |
| Street | Apt. | | Employer | Occupation |
| City | State | Zip | Street | |
| Home Phone () | Business Phone () | | City | State Zip |

Referring Doctor:

| | | | |
|--------|-------|--------|--------------|
| Last | First | Middle | Phone () |
| Street | City | | State Zip |

If we have a need for any additional information, what is your day time phone number: _____

Primary Insurance:

Secondary Insurance:

| | | | |
|---|------------------|---|------------------|
| Insurance Co. Name | Telephone () | Insurance Co. Name | Telephone () |
| Address to Mail Claim | | Address to Mail Claim | |
| City | | City | |
| Name of Person Holding Contract (Insured) | | Name of Person Holding Contract (Insured) | |
| Group No. | Policy No. | Group No. | Policy No. |
| Beginning Coverage Date | | Beginning Coverage Date | |
| Is this and HMO or PPO? | | Is this and HMO or PPO? | |

If you are using this form to update insurance information:
Name of Insurance ending: _____ As of What Date: _____

I. Financial Agreement

I hereby assume full responsibility for all charges incurred for professional services rendered by Emory Clinic physicians, unless the services are deemed "paid in full" as a result of a contractual agreement between The Emory Clinic and my insurer.

II. Authorization for Release of Information

I hereby authorize The Emory Clinic to release any medical, psychiatric, infectious disease (including AIDS confidential information) or drug and/or alcohol related information to my referring physician and any insurance company with whom I have medical benefits for the purpose of filling a medical claim. I acknowledge that this authorization is valid until such time as all medical bills related to my treatment have been paid. I further understand that I can withdraw this consent for release of information at any time prior to this expiration date except to the extent that action has been taken in reliance hereon.

III. Group & Individual Insurance, Assignment of Benefits

I authorize my health insurance benefit plan to pay directly to The Emory Clinic, the surgical and/or medical, if any, otherwise payable to me for their services as described on attached claim but not to exceed the charges for those services. I understand I am financially responsible to the Clinic for charges not covered by this assignment.

IV. Medicare, Claim Authorization and Payment Request

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to either myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature: _____ **Date:** _____