Timarron
Family Medicine
Esthetics
Regenerative Medicine

PATIENT REGISTRATION FORM

PATIENT DEMOGRAPHICS

First Name	Last Name
Date of Birth	Social Security No
Address	City
State	Zip
Home Phone	Cell Phone
Marital Status	Email
Employer	Occupation
Pharmacy Name	Pharmacy Location

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Policy Subscriber	Policy Subscriber
Subscriber DOB	Subscriber DOB
Subscriber SSN	Subscriber SSN
Subscriber Employer	Subscriber Employer

EMERGENCY CONTACT INFORMATION

Name	Name
Phone	Phone
Relationship to Patient	Relationship to Patient

I consent to receive communications from Timarron Family Medicine in an electronic form and agree that all terms and conditions, agreements, notices, disclosures, and other communications that Timarron Family Medicine provides to you electronically satisfy any legal requirement that such communications would satisfy if it were be in writing. _____

By signing below, I attest that the information provided above is true and accurate.

Signature of Insured/Guardian: _____

Date: _____

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PAYMENT POLICY

All copays and deductible amounts are due at time of service. We accept cash, personal checks as well as MasterCard, Visa and Discover. There will be a $25.00 charge for all returned checks. Your services are always filed to your insurance; usually within 2 business days of your visit. Payment from your insurance is expected within 45 days of said visit. If you are not on one of the many insurances that we accept or this is a third party billing situation then full payment is expected at the time services are rendered. If there is a patient balance due on your account you will receive monthly statements from the office and accounts over 60 days past due are subject to collections.

There will be a 1.5% finance charge on accounts after 30 days. If the account remains unpaid for 90 days and there has been no attempt by the patient or legal guardian to make payment arrangements, or failure to comply with previously set payment schedule the account may be turned over to a collection agency. It is up to the patient to know your insurance coverage and to keep us notified of any changes with your insurance policy. Any non-covered services will be your responsibility and will be billed directly to you.

Please note there is a $60.00 fee for not showing up/late canceling your appointments. The fee increases to $100.00 for not showing up/late canceling for physical exams. If you are unable to keep your scheduled appointment we do require 24 hours' notice.

Patients not signed up for a Tiered Access Health Plan will be charged a $25.00 Administration Fee for their first three visits of the year. This fee is in response to the increasing cost of running a business in today's health care environment. This fee is non-negotiable. For more information on the Tiered Access Health Plan please see the front desk or visit our website at www.timarronfamilymedicine.com.

I consent to the treatment for the care of the patient indicated on this registration form. I hereby authorize assignment of all medical insurance benefits to Timarron Family Medicine for services rendered. Authorization is hereby granted to release information as may be necessary to process and complete insurance claims. I also authorize release of information necessary to complete referrals to other healthcare facilities as deemed necessary by my primary physician.

Patient/Legal Guardian Signature: _____

Date: _____