

CAEDEL MEDICAL GROUP, PC

Patient Registration

Demographic Information:

Name: _____ SS#: _____ DOB: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Phone: Home _____ Work: _____ Cell: _____

Email: _____

How would you prefer to receive appointment reminders? Phone Text Message _____
Phone Number

Please list race: American Indian Or Alaska Native Asian Native Hawaiian or Other Pacific
 Black or African American White Hispanic Other Race

Please list ethnicity: Hispanic or Latin Non Hispanic or Latin Refuse to Report

Please list spoken language: English Spanish Russian Other

Insurance Information:

Insurance Company: _____ Policy Number _____

Group Number: _____ Policy Holder Name: _____ DOB: _____

My Relationship with policy holder is? _____

Please list your preferred pharmacy

Pharmacy Name **City** **Phone Number**

ASSIGNMENT OF BENEFITS/AUTHORIZATION OF TREATMENT

I hereby authorize medical treatment by the medical providers of Caedel Medical Group, PC and I authorize the provider of medical services to release information for these services to my insurance carrier for payment. I understand that I am financially responsible for all charges not covered by my insurance company.

Patient Signature

Date

CAEDEL MEDICAL GROUP, PC

Patient Financial Policy

Thank you for selecting our practice as your healthcare provider. We are committed to providing you with compassionate and quality medical care. Please understand that payment is expected for services rendered. The following is a statement of our financial policy. Please read, sign and date this policy prior to treatment. Please provide any current medical insurance cards that should be used to cover services rendered. For your convenience, our practice accepts Visa, MasterCard, Discover, American Express, Cash, and Personal Checks.

Insurance

We accept assignment of benefits for most insurance plans. However, we do require that all co-payments, co-insurance and deductibles be paid at the time of service.

Your insurance policy is a contract between you and your insurance carrier. You are responsible for providing our practice with the correct insurance information at the time of service or you may be responsible for the charges in full. Should your insurance company fail to pay the insurance claim for services rendered by Caedel Medical Group, you may be responsible for the entire charge submitted to the insurance carrier. Therefore, we recommend that you follow-up with the insurance carrier if your claim has not been paid within 30 days from the date the claim was submitted.

You are also responsible for determining what services your insurance company covers. Therefore, if your insurance coverage is verified and certain procedures are not covered, you will be required to sign a waiver indicating that you understand that your policy does not cover this service and you will be responsible for the charges associated with this service.

Co-insurance and any balances that remain the responsibility of the patient, according to the insurance terms, should be remitted to the practice upon notice of balance due. **Failure to remit payment may result in your patient account being turned over to an outside collection agency. Any account turned over to an outside collections agency will incur a 30% collection agency fee and these fees will become the responsibility of the patient.**

Non-Insured Patients

Patients that are not covered by an insurance plan are responsible for services rendered at the time of service. For patients unable to pay for services in full, a minimum of 50% of the charges are due at the time of services. Payment for any remaining balance is payable within 30 days of the date of services. **Failure to remit payment may result in your patient account being turned over to an outside collection agency. Any account turned over to an outside collections agency will incur a 30% collection agency fee and these fees will become the responsibility of the patient.**

Missed Appointments

Please help us serve you better by keeping scheduled appointments. In the event you are unable to keep your appointment, please kindly give us a 24 hour notice. Failing to provide notice of cancellation for two or

more consecutive visits, will result in a \$25.00 missed appointment charge. This charge is the responsibility of the patient and it is not covered by most insurance carriers.

Forms

Disability, Life Insurance and other forms are often requested to be completed by the practice. Many of the forms require review by the physicians and completion of detailed medical history questionnaires. Please allow 7-15 days for completion of any requested forms. The charge for this service is \$25.00 cash. This charge is payable upon submission of the forms, therefore forms will not be completed unless pre-payment is made.

CAEDEL MEDICAL GROUP, PC

Outstanding balances
All outstanding balances that are not paid

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and agree to abide by the financial policy of Caedel Medical Group.

X _____
Patient Signature

Date