

# REGISTRATION

(PLEASE PRINT)

PATIENT NAME  
 LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_ GENERATION \_\_\_\_\_  
 GUARANTOR \_\_\_\_\_ Is the guarantor the legal representative?  Yes  No  
 SOCIAL SECURITY NO. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 ACCOUNT NO. \_\_\_\_\_ SEX:  Male  Female DATE OF BIRTH \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_  
 \_\_\_\_\_ EMPLOYMENT STATUS \_\_\_\_\_  
 CITY \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
 STATE \_\_\_\_\_ ZIP \_\_\_\_\_ BUSINESS ADDRESS \_\_\_\_\_  
 HOME PHONE \_\_\_\_\_ ALLERGIES \_\_\_\_\_  
 CELL PHONE \_\_\_\_\_ CURRENT MEDICATIONS \_\_\_\_\_  
 WORK PHONE \_\_\_\_\_ EXT. \_\_\_\_\_

NAME OF GUARANTOR: LAST \_\_\_\_\_ FIRST \_\_\_\_\_  
 WHO IS RESPONSIBLE FOR THIS ACCOUNT? \_\_\_\_\_  
 RELATIONSHIP TO PT: \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ **DOB:** \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 PRIMARY PHONE \_\_\_\_\_ EXT. \_\_\_\_\_ ALTERNATE PHONE \_\_\_\_\_ EXT. \_\_\_\_\_  
 FAX \_\_\_\_\_ GUARANTOR COMMENT \_\_\_\_\_  
 DO YOU HAVE MEDICAL INSURANCE?  Yes  No If YES, please fill out the following information.  
 NAME OF INSURANCE \_\_\_\_\_ NAME OF PRIMARY INSURER \_\_\_\_\_  
 CONTRACT NO. \_\_\_\_\_ GROUP NO. \_\_\_\_\_ ID NO. \_\_\_\_\_  
 NAME OF SECONDARY INSURANCE \_\_\_\_\_  
 CONTRACT NO. \_\_\_\_\_ GROUP NO. \_\_\_\_\_ ID NO. \_\_\_\_\_  
 MEDICARE  AUTO  WORKER'S COMP CLAIM ID NO. \_\_\_\_\_ COUNTY OF \_\_\_\_\_

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?  
 NAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_ CELL/WORK PHONE \_\_\_\_\_  
 HOW DID YOU LEARN ABOUT OUR PRACTICE? \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with (name of insurance company) \_\_\_\_\_  
 and assign directly to Dr. \_\_\_\_\_ all medical benefits, if any, otherwise payable to me for services  
 rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all  
 information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

\_\_\_\_\_  
Signature of Insured/Guardian

\_\_\_\_\_  
Date

## MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. \_\_\_\_\_  
 for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration  
 and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that  
 payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA  
 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer  
 or agency shown in Medicare assigned case. The physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge,  
 and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge  
 determination of the Medicare carrier.

\_\_\_\_\_  
Beneficiary Signature

\_\_\_\_\_  
Date

**PATIENT INSURANCE NOTICE**

YOUR INSURANCE COMPANY WILL PAY ONLY FOR THE SERVICES THAT IT DETERMINES TO BE REASONABLE AND CUSTOMARY ACCORDING TO THEIR OWN SURVEYS. IF YOUR INSURANCE COMPANY DETERMINES THAT A MEDICAL SERVICE IS NOT REASONABLE AND CUSTOMARY UNDER THEIR PARTICULAR PROGRAM STANDARDS, THEY WILL DENY THE CHARGES. PLEASE REVIEW YOUR TREATMENT PLAN WITH THE PHYSICIAN PRIOR TO THE SERVICES RENDERED. DOCTOR'S INN IS NOTIFYING YOU THAT YOU WILL BE RESPONSIBLE FOR ALL CHARGES THAT ARE DENIED BY YOUR INSURANCE COMPANY. YOU WILL BE EXPECTED TO PAY THE FULL BALANCE FOR THESE SERVICES. IF YOU ARE IN DOUBT REGARDING YOUR INSURANCE COVERAGE, PLEASE CONTACT YOUR CARRIER BEFORE YOU RECEIVE THE TREATMENT NECESSARY. WE WILL OF COURSE, HONOR ALL OF THE INSURANCE DISCOUNT AMOUNTS FOR COVERED CHARGES OF ALL OF THE PLANS THROUGH WHICH WE ARE A CONTRACTED PROVIDER. IF YOU HAVE ANY QUESTIONS, PLEASE SPEAK WITH OUR STAFF.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**HIPPA**

I HAVE READ THE NOTICE OF PRIVACY PRACTICES FOR DR. ROBERT FEDOR, AND I HAVE BEEN PROVIDED SUFFICIENT OPPORTUNITY TO REVIEW THE DOCUMENT.

NAME (PRINT): \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_