

# Dependent Patient Registration

Date \_\_\_\_\_  
Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ Work/Other ( ) \_\_\_\_\_  
Email Address \_\_\_\_\_  
Preferred Method of contact for REMINDER CALLS (please ONLY check one of the following):  
\_\_\_\_\_ Email, \_\_\_\_\_ Cell phone (TEXT), \_\_\_\_\_ Cell phone (CALL), \_\_\_\_\_ Home phone (call)

Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Gender \_\_\_\_\_ M \_\_\_\_\_ F Birth Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Month Day Year

Mothers Name \_\_\_\_\_ Birth Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First Middle Month Day Year

Fathers Name \_\_\_\_\_ Birth Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First Middle Month Day Year

How did you hear about us?? \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Refused

## Primary Insurance Information

Policy Holder \_\_\_\_\_  
Last First Middle

Relation to patient \_\_\_\_\_ Birth Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
COPAY: \$ \_\_\_\_\_ Month Day Year

Employer \_\_\_\_\_ Employer Phone # ( ) \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insurance Phone # ( ) \_\_\_\_\_

Insurance Billing Address \_\_\_\_\_

Group# \_\_\_\_\_ ID/Subscriber# \_\_\_\_\_

## Secondary Insurance Information

Policy Holder \_\_\_\_\_  
Last First Middle

Relation to patient \_\_\_\_\_ Birth Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Month Day Year

Employer \_\_\_\_\_ Employer Phone # ( ) \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insurance Phone # ( ) \_\_\_\_\_

Insurance Billing Address \_\_\_\_\_

Group# \_\_\_\_\_ ID/Subscriber# \_\_\_\_\_

\*\*\*Emergency Contact \_\_\_\_\_ Phone( ) \_\_\_\_\_

I the undersigned certify that I (or my dependent) have insurance coverage with the above listed insurance company and assign all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I agree to pay interest at 11/2% per month. If it becomes necessary to refer this account to a collection agency, I agree to pay a collection fee of 35% of the principal balance owing. I agree to pay \$25.00 for any missed appointments and appointments canceled with less than a one hour notice of the appointment time. Further I agree to pay for any and all attorney fees and court cost incurred, should litigation become necessary.

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship \_\_\_\_\_

## Patient Authorization for Practice to Release Protected Health Information to Third Parties

By signing this authorization, I authorize CopperView Medical Center to use and/or disclose certain protected health information (PHI) about me or my child to or for the party or parties listed below.

This authorization permits CopperView Medical Center to use or disclose to the following list of people(s)....

_____	_____ / _____ / _____	_____	_____ / _____ / _____
Name	Date of Birth	Name	Date of Birth
_____	_____ / _____ / _____	_____	_____ / _____ / _____
Name	Date of Birth	Name	Date of Birth

(person or entity receiving the information) the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.)

This authorization will expire on \_\_\_\_\_  
(Expiration Date or Defined Event)

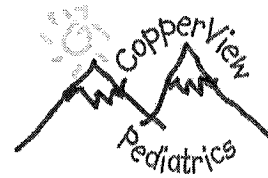
When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that CopperView Medical Center has acted in reliance upon this authorization. My written revocation must be submitted to CopperView Medical Center's Privacy Officer.

Signed by: \_\_\_\_\_ (Date) \_\_\_\_\_  
(Signature of Patient or Legal Guardian)

Print Name of Patient or Legal Guardian \_\_\_\_\_



# CopperView Medical Center



## FINANCIAL POLICY AND AGREEMENT

Thank you for choosing CopperView Medical Center as your healthcare provider. We are committed to excellent patient care. The following is an explanation of our financial policy and agreement, which you must read and sign prior to any medical evaluation or treatment.

1. Each patient is responsible for his or her own bill.
2. Payment of all insurance co-payments and deductibles is required at the time of service. What your insurance does not cover and you are responsible to pay, is a contract between you and your insurance company.
3. Patients who have no insurance are required to pay 100% of services rendered at each visit. If this is not possible, you will need to make payment arrangements with our billing office. We accept; cash, Visa/MasterCard, American Express, and Discover/Novus. If a check is accepted (with approval from office manager) a \$20 fee will be charged on all returned checks.
4. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. Your bill is your responsibility whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.
5. You are responsible for knowing what your insurance covers and the providers and network(s) covered under your health insurance plan. Any service provided, but not covered by your insurance company, will be your responsibility to pay.
6. You are responsible for any laboratory service performed at these facilities that are sent out to a third party laboratory for processing. All billing for laboratory services are generated through the lab itself; we do however provide your insurance information to the lab for billing purposes only.
7. If for any reason, should collection become necessary, the responsible party agrees to pay an additional 40% collection fee of any charges being sent to the collection agency, and all legal fees of collection with or without suit including attorney fees and court fees.
8. Be aware that we may charge a \$25.00 fee for no-showed appointments.
9. Be aware for any inadequate cancellation; defined as one hour or less of your appointment time, may be charged a \$25.00 fee.

### Usual and Customary Rates

Our rates for medical services reflect the usual and customary rates in the community.

### Authorization to Pay Benefits

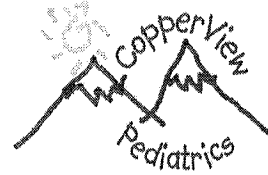
I further authorize and direct said agency, attorney or insurance company to pay from the proceeds of benefits of any recovery or insurance payments in my case, directly to the providers of this office, for their professional services rendered. I understand that this in no way relieves me of my personal responsibility for payment to my provider when a statement is rendered.

\_\_\_\_\_  
Signature of patient or responsible party

\_\_\_\_\_  
Date



# CopperView Medical Center



Date: \_\_\_\_\_

I, \_\_\_\_\_, a parent, or legal guardian of:  
(please print)

List Child(ren)/Patient Name(s):

Account Number:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_

was made aware that there is a copy of the CopperView Medical Center Notice of HIPAA Privacy Practice, located in the waiting are. If I desire to obtain a copy of the Privacy Practice Pamphlet, one can be obtained from the receptionist desk. I have been informed that should I have questions regarding this Privacy Policy or do not understand the information in the Notice that I may direct these questions to the Privacy Officer.

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date