HILLCROFT MEDICAL HMC CLINIC ASSOCIATION

PATIENT #

CLERK:

PATIENT REGISTRATION IF OTHER THAN RESPONSIBLE PARTY

PLEASE PRINT

YOUR NAME ☐ MR. ☐ MS. ☐ MRS. ☐ MISS FIRST M.I. LAST		YOUR SOCIAL SECURITY #	YOUR DATE OF BIRTH
YOUR MAIL ADDRESS STREET, P. O. BOX, RURAL ROUTE, APT.		YOUR HOME PHONE #	YOUR AGE
CITY STATE ZIP		YOUR WORK PHONE # EXT.	YOUR SEX ☐ M ☐ F
EMPLOYER	EMPLOYER ADDRESS CITY STATE ZIP		

PERSON RESPONSIBLE FOR PAYMENT (GUARANTOR)

PLEASE PRINT

YOUR NAME ☐ MR. ☐ MS. ☐ MRS. ☐ MISS FIRST M.I. LAST	YOUR SOCIAL SECURITY #	YOUR DATE OF BIRTH
YOUR MAIL ADDRESS STREET, P. O. BOX, RURAL ROUTE, APT.	YOUR HOME PHONE #	MARITAL STATUS
CITY STATE ZIP	YOUR WORK PHONE # EXT.	YOUR SEX ☐ M ☐ F
YOUR EMPLOYER	YOUR SPOUSE	
YOUR EMPLOYER'S ADDRESS STREET, P. O. BOX, RURAL ROUTE, SUITE	YOUR SPOUSE EMPLOYER	
CITY STATE ZIP	YOUR DRIVERS LICENSE #	STATE

IN CASE OF EMERGENCY, PLEASE CONTACT NEAREST RELATIVE OR:

NAME ☐ MR. ☐ MS. ☐ MRS. ☐ MISS FIRST M.I. LAST	RELATIONSHIP	DAY TIME PHONE #
ADDRESS STREET, P. O. BOX, RURAL ROUTE, APT. CITY STATE ZIP		

REFERRED BY

RELEASE OF RECORDS

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION OBTAINED AND DOCUMENTED BY HILLCROFT MEDICAL CLINIC DURING MY COURSE OF TREATMENT TO MY INSURANCE CARRIER.

SIGNATURE	DATE
X	

FINANCIAL RESPONSIBILITY STATEMENT

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO HILLCROFT MEDICAL CLINIC. I REALIZE THAT I AM RESPONSIBLE FOR PAYING THE CO-PAYS, DEDUCTIBLE, CO-INSURANCE AND NON-COVERED SERVICES AS DETERMINED BY MY INSURANCE CARRIER. FURTHERMORE, I HEREBY VERIFY THAT I HAVE NO OTHER INSURANCE COVERAGE, PRIMARY OR SECONDARY, OTHER THAN THE CARRIERS LISTED BELOW.

SIGNATURE	DATE
X	

MEDICAL INSURANCE INFORMATION

PRIMARY CARRIER	VERIFICATION PHONE #	INSURED'S SOC. SEC. #	GROUP NO.
CLAIM MAILING ADDRESS		POLICY NUMBER	EMPLOYER
CITY STATE ZIP		TYPE OF INSURANCE ☐ HMO ☐ PPO ☐ MediCare ☐ MediCaid ☐ Workers Comp ☐ Other	
SECONDARY CARRIER	VERIFICATION PHONE #	INSURED'S NAME	
CLAIM MAILING ADDRESS		POLICY NUMBER	EMPLOYER
CITY STATE ZIP		TYPE OF INSURANCE ☐ HMO ☐ PPO ☐ MediCare ☐ MediCaid ☐ Workers Comp ☐ Other	

MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION AND INFORMATION RELEASE

Patient's
Name_______________________________________ Medicare I.D. number_________________

I request that payment of authorized Medicare benefits be made either to me or on my behalf to (name of physician/supplier) for any services furnished me by that physician/supplier. 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 to 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 claim 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 cases, 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.

_______________________________________ _______________________________

Patient's Signature Date