Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT

Last Name: _____
First Name: _____
Middle Name: _____
Address: _____
City: _____ State: _____
Zip: _____
Home Phone: _____
Work Phone: _____
Mobile Phone:_____
Sex: _____
Date of Birth: _____
Social Security No.:_____
Patient email: _____
Required by government mandate [although you may refuse]:
Language: _____
Race: _____
Ethnicity: _____
Marital Status: _____

Guarantor Information (to whom statements are sent)

Name: _____
Address: _____
, _____
Relationship to patient: _____
Date of Birth: _____
Social Security No.: _____
Phone: ( ) _____ - _____

Employer information

Employer: _____
Address: _____
Phone: _____

Other

Patient Referred by:_____

Primary Care Provider:_____

Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email

Emergency Contact Information

Name: _____
Relationship: _____
Phone: _____
Mobile Phone:( ) _____ - _____

Primary Insurance Information

Insurance Plan Name: _____
Last Name:_____
First Name: _____
Middle Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ Sex (please circle): **M** or **F**
Employer Name: _____
Patient's relationship to policy holder:_____

Pharmacy Information:

Name:_____

Crossroads:_____

Phone:_____

Secondary Insurance Information

Insurance Plan Name: _____
Last Name: _____
First Name.: _____
Middle Name:_____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ Sex (please circle): **M** or **F**
Employer Name: _____
Patient's relationship to policy holder:_____

To the best of my knowledge the above information is complete and accurate.

Signed_____ **Date:**_____

ACKNOWLEDGEMENT AND AUTHORIZATION:

- I have read and understand the HIPAA/Privacy Policy for BRADEN CLINIC LLC

Signed_____ Date:_____

- I hereby assign my insurance benefits to be paid directly to the healthcare provider

Signed_____ Date:_____

- I authorize BRADEN CLINIC LLC to release medical information required to process my claim

Signed_____ Date:_____

- I have read and understand the Financial Policy for BRADEN CLINIC LLC

Signed_____ Date:_____

- I authorize BRADEN CLINIC LLC to obtain/have access to my medication history

Signed_____ Date:_____

- I authorize my provider's office to contact me by mobile phone

Signed_____ Date:_____

Braden Clinic

5050 Ave Maria Blvd.
Ave Maria, FL 34142

Dr. Beau R. Braden, DO, Dr. Buck A. Braden, DO, Anthony J. Musingo, PA-C, Taresa B. Fassbender, PA-C

Date _____

I Do give the Braden Clinic, LLC my permission to discuss protected health information pathology, lab testing, radiology or any other protected health information with the following:

Full Name	Relationship to the patient
Full Name	Relationship to the patient

I Do give the Braden Clinic, LLC my permission to discuss billing/payment information with the following:

Full Name	Relationship to the patient
Full Name	Relationship to the patient

I Do give the Braden Clinic, LLC my permission to access my medication list from pharmacy databases. This will ensure that my healthcare providers have my most updated medication list on file at all times. (Circle One)

Yes No

May we leave a message on your answering machine at home concerning pathology, lab testing, radiology or any other protected health information? (circle one)

Yes No

May we leave a message at home confirming or cancelling an appointment?

Yes No

May we leave a message at your place of employment to have you return our call?

Yes No

I understand that I can change or rescind this authorization at any time. I understand that I must submit a rescind or notice of change in writing.

Printed name of patient	Signature of Patient

Witness from Braden Clinic, LLC

Our Financial Policy

This policy covers office visits, labs or radiology testing. By signing this document, I am agreeing to the terms of this Financial Policy.

Payment is at time of service: Payment is due in full at the time of service unless you are covered by Medicare or an insurance company with which we participate. You will be charged a $25 service fee for any returned checks, no exceptions.

Insurance: Patients will be asked to present their insurance card to the receptionist for copying upon check-in at the office each time they are seen for medical services. Please make it a point to bring your insurance card with you each time that you visit our office. Claims not paid within 45 days by your insurance company will become your responsibility. You will receive a statement for these services and you will need to contact your insurance company for reimbursement.

For those patients covered by insurance plans with which we ARE participating providers, all co-payments, deductibles and non-covered services are due at time of service. We will file the insuranceclaim to the insurance company. In the event that your insurance coverage changes to a plan with which we ARE NOT participating providers, we will require payment in full at the time of service and we will file your claim to the insurance company as a courtesy. Any charges that are not paid by your insurance company are your responsibility. Your insurance policy is a contract between YOU and your insurance company. Any pre-certifications of procedures or testing are your responsibility. Please let us know in advance if your insurance company requires this.

Collections: Please note, if payment is not received from eithr you or your insurance company within 60 days from the date of service(s), your account will be considered delinquent and subject to referral to an outside collection agency.

_____ _____

Signature of Patient Date

_____

Printed Name of Patient

Financial Policy and HMO Waiver

Dear Patient,

For those patients covered by insurance plans with which we ARE participating providers, all co-payments, deductibles and non-covered services are due at the time of service. We will file the insurance claim to your insurance company.

In the event that your insurance coverage is with a plan with which we are NOT participating providers, or you have an HMO plan which requires pre-certification, we will require payment in full at the time of service. We will file your claim to the insurance company as a courtesy, however, any charges that are NOT paid by your insurance company are your responsibility.

Your insurance policy is a contract between YOU and your insurance company. Any pre-certifications for office visits, procedures, or testing are your responsibility. Please let us know in advance if your insurance requires any pre-certification. Any uncovered charges due to lack of pre-certification will be YOUR responsibility.

By signing below, I understand that all charges not covered by my insurance, or if my insurance is out of network, or a pre-certification for my HMO was not obtained prior to being seen, are my responsibility.

_____ _____

Signature of Patient Date

_____

Printed Name of Patient