Family Medicine Associates

A Division of Abbeville County Memorial Hospital

Patient Registration

Patient Name	Date of Birth	Sex M F	SS#
Last First Middle		Circle One	

Street Address	City	State	Zip	Home Phone # (or # where you can be reached)

Mailing Address (If Different)	Married	Single	Divorced	Widowed
	[ ]	[ ]	[ ]	[ ]

Place of Employment (If minor, see below)	Work Phone #

Spouses Name	Spouses Place of Employment	Spouses Work Phone #

Other Family Members to be included on this account

If Patient is Minor or Student

Mothers Name	Mothers Place of Employment	Mothers Work Phone #

Fathers Name	Fathers Place of Employment	Fathers Work Phone #

Notify In Case Of Emergency: Name_____ Phone #_____

PLEASE PROVIDE INSURANCE CARDS AT FRONT DESK.

INSURANCE INFORMATION (All blanks must be completed and filled out for the *POLICY HOLDER*)

Insurance Company	Group No. / Policy No.	Policy Holder Name	Date Of Birth	Social Security No.	Work Place
1.					
2.					
3.					

Financial Policy:

Adult Patients: Adult patients are responsible for full payment at time of service.

Minor Patients: The parent or guardian accompanying a minor is responsible for full payment at time of service. For unaccompanied minors, non emergency treatment will be denied unless charges have been preauthorized.

Regarding Insurance: We will file your insurance if we participate in your plan. However, copays, deductibles or your percentage after deductible has been met should be payed at the time of service. If you have any change in your insurance status, please inform the receptionist. Once you receive a billing statement, the amount due is your responsibility.

Missed Appointments: We ask that you contact our office at least 24 hours in advance when possible. Please help us serve you better by keeping scheduled appointments. Patients may be dismissed after three (3) missed appointments unless the office was contacted beforehand.

I have read the Financial Policy (above). I understand and agree to this Financial Policy.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Family Medicine Associates to furnish information to my insurance carriers concerning my illness and/or treatment, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependants. I understand that I am responsible for any amount not covered by my insurance. I authorize use of a photostatic copy of this assignment in lieu of the original when necessary.

X_____ **Date**_____

Patient's Signature or Responsible Party