Return Patient Registration

Please help us update your medical file by providing information below.

PATIENT INFORMATION

Name: ________ Date of Birth: ________

Street Address: ________ Apt# ____ Patient Phone: ________

City: ________ State ____ Zip ____

Preferred Pharmacy: ________ Pharmacy Phone: ________

REASON FOR VISIT

INSURANCE INFORMATION

Primary Insurance: ________ Secondary Insurance: ________

Plan: ________ Plan: ________

Subscriber Name: ________ Subscriber Name: ________

Date of Birth: ____ Relationship: ____ Date of Birth: ____ Relationship: ____

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

☐ Check if same as patient information. If not, please complete the entire section.

Name: ________ ☐ Male ☐ Female Relationship: ________

Date of Birth: ____ SS#: ____ Phone #: ________

I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office are due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event my account is turned over to a collection agency, I agree to pay all costs of collection fees and/or attorney's fees and all court costs if any. I agree to give AFC, its employees and/or its agents permission to contact me at any telephone number or email address associated with my account. This includes cellular telephone numbers or other wireless devices. I understand this could result in a charge from my phone or device carrier to me for talk time, SMS messaging/texts or data usage for emails or voice mails. I also understand methods of contact may include pre-recorded /artificial voice messages and/or the use of automatic dialing devices as applicable.

Signature ________ Date ________

CONSENT FOR TREATMENT

I, the undersigned, consent to the care and treatment by the attending Physician, his/her associates or assistants and acknowledge that no guarantees have been made as to the effect of such treatment.

Signature ________ Date ________

NOTICE OF PRIVACY PRACTICES (SEE ATTACHED)

I have reviewed the Notice of Privacy Practices as provided at registration and understand that I may request a copy of the policy at any time.

Signature ________ Date ________