

PLEASE READ THOROUGHLY AND SIGN ALL HIGHLIGHTED AREAS

America's Family Doctors PLLC (AFD) Registration Form

Patient Information:

First: _____ Middle: _____ Last: _____ Gender: M F

Date of Birth: ____/____/____ Marital Status: D M S W SS#: ____/____/____

Address: _____ Apt# _____ City/State: _____

Zip: _____ Phone(Home) _____ (Cell) _____ (Work) _____

E-Mail address: _____ Can we email you lab & test results? Yes ___ No ___

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Insurance	
Subscriber Name:	_____
Birth Date:	____/____/____ SS #: ____/____/____
Relationship:	_____
Employer Name:	_____
Insurance Policy ID #	_____

Secondary Insurance	
Subscriber Name:	_____
Birth Date:	____/____/____ SS #: ____/____/____
Relationship:	_____
Employer Name:	_____
Insurance Policy ID #	_____

Patient Employer:	_____
Address:	_____
City/State:	_____ Zip: _____

Financially Responsible Party (if different than patient)	
First:	_____ Last: _____
Date of Birth:	____/____/____ Gender: M F
SS#	____/____/____ Relationship: _____
Address:	_____
City/State:	_____ Zip: _____
Employer:	_____
Address:	_____
Phone:	_____

Insurance Authorization and Financial Responsibility Informed Consent: I authorize *AFD* to furnish information to **insurance carriers** concerning my care. I agree to pay *AFD* for all services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance. For Self-Pay patients, I also understand that I am responsible for all services rendered to my dependents or myself. The responsible party would pay for any fees that may be charged by a collections agency. **If any tests are performed by the lab you may receive a separate bill from their offices that you are financially responsible for. Full payment for AFD services provided is due at the time of service or Fees and Interest may be charged.**

Consent to Treat and Medical Records Release Authorization: I authorize *AFD* medical providers to provide treatment that they deem advisable for my dependents or myself. I understand these services are voluntary and I have a right to refuse these services. In the event of a life-threatening emergency, I consent for the providers to administer emergency treatment. I authorize *AFD* to obtain any previous medical records, for myself or my dependents, including lab and X-Ray results, if my providers feel it is necessary for my care.

If you accrue additional charges while in office and are SELF PAY, you must pay additional charges before leaving the office. If you choose to pay by credit card and you leave the office without paying additional fees, your credit card will be charged and the receipt will be mailed.

Please note: WE DO NOT PRESCRIBE NARCOTIC OR ADDICTIVE MEDICINES.

By signing this form, I acknowledge that I have received a copy of AFD's Privacy Policy (HIPAA).

Pharmacy you prefer to use _____
Address _____
Phone _____

Signature: _____ **Date:** _____

How did you hear about us: _____

Copy of Insurance Card and ID is required for everyone.