

JAMES A. HALEY, M.D., P.A.

PATIENT REGISTRATION

DATE: _____
NAME: _____ SEX: ___F___M BIRTHDATE: _____
ADDRESS: _____ HOME PHONE: _____
CITY: _____ STATE: _____ ZIP: _____ MARITAL STATUS S M W D
SS#: _____ REFERRING DOCTOR: _____

INSURANCE INFORMATION

PRIMARY	SECONDARY
_____	_____
_____	_____
GROUP#: _____	GROUP#: _____
ID#: _____	ID#: _____
INSURED: _____	INSURED: _____

EXTENDED INFORMATION

PATIENT'S EMPLOYER: _____ PHONE: _____
INSURED'S NAME: _____ PHONE: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
EMPLOYER: _____ BIRTHDATE: _____ SS#: _____
PERSON TO NOTIFY IN AN EMERGENCY: _____ PHONE: _____

OUR FEE POLICY: To help control costs we ask our patients to pay their office visits at the time service is rendered.

I understand that I am financially responsible to the physician for the charges incurred by myself and/or my dependents.

SIGNED: _____ DATE: _____

ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plans to **JAMES A. HALEY, M.D.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNED: _____ DATE: _____

PLEASE SEE BACK

It is the policy of our office that all visits must be paid for at the time of service. The only exception to this policy are those P.P.O. or H.M.O. patients for which we are a provider.

Returned checks and balances older than 30 days may be subject to additional collection fees. As a service to our patients we will file claims to your primary insurance carrier. However, it is up to the patient to file any secondary insurance policy.

If your insurance has not paid within 45 days after your claim is filed, we will hold you responsible for payment in full.

Our fees are consistent with those charged by other physicians in this area. If for any reason your insurance carrier states that our fees are above reasonable and customary, you will be responsible for the difference.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this form and have completed the requested information. I will notify this office of any changes in this information.

I consent to and authorize Dr. James A. Haley, M.D. to treat any conditions that I might have and seek treatment for.

PATIENT SIGNATURE: _____ DATE: _____