Internal Medicine Urgent Care Minor Trauma Occupational Medicine

REGISTRATION FORM

Date: _____

Patient Name: _____

Address: _____
City, State, Zip: _____

Date of Birth: _____ **Social Security #:** _____
Home Phone #: _____
Sex: Female_____ Male _____

Allergies: _____

Primary Insurance: _____ Secondary Insurance: _____

Emergency Contact: _____
Emergency Phone #: _____
Spouse Name: _____ S.SN: _____

Employer: _____ Work Phone #: _____

CHECK-OUT NOTE

PLEASE STOP at CHECK-OUT COUNTER before leaving our office. Payment for office services is due on the day of service. As part of our service we will submit your insurance claims. Insurance/Financial arrangements should be made with our patient patients' relations department prior to SURGERIES.

FINANCIAL RESPONSIBILITY

I acknowledge that I am responsible and liable for all charges accessed for professional services rendered. I acknowledge that I am responsible for all charges regardless of my existing medical coverage. In the event my insurance company forwards payment directly to me, I will deliver such payment to Calvary Medical Clinic, P.A... I understand that I am responsible for meeting my insurance deductibles and co-insurance and any non covered services. Should my account become past due, the balance shall become immediately due and payable.

RELEASE OF INFORMATION and ASSIGNMENTS OF BENEFITS DECLARATION

I hereby authorize release of any medical information necessary to process my insurance claim and also ASSIGN to the DOCTOR all payments from MEDICARE, BLUE CROSS/SHIELD Insurance for services rendered. I further authorize the release to my insurance company of any medical information necessary to process a claim, and hereby assign payment of all medical benefits to Calvary Medical Clinic, P.A.

I understand and agree to all the above conditions.

_____ _____
Date Signature

2315 W. Arbors Drive, Suite 200 Charlotte, NC 28262
Tel: (704) 979 8210 **www.calvarymedicalclinic.com** Fax: (704) 979 8510
COMPLETE CARE IN A COMPASSIONATE ENVIRONMENT

QUESTIONS AND COMPLAINTS

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to Protected Health Information.

If you want more information about our privacy practices or have questions or concerns, please contact us at (704) 979 8210.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Services upon request.

Contact Office: Calvary Medical Clinic P.A.
Address: **2315 W. Arbors Drive, Suite 200 Charlotte, NC 28262**
Telephone: (704) 979 8210

Please list 3 names of people who have your permission to obtain your medical records:

1. _____
2. _____
3. _____

I have read and or been given a copy of this privacy act.

_____ _____
Signature Date