ENCOMPASS
MEDICAL GROUP

REGISTRATION FORM

Location: _____Provider: _____ Today's Date: _____

Please complete each field on this form. When completed return to the front desk.

GENERAL INFORMATION

Last Name: _____ First Name: _____ DOB: _____

SSN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email: _____

INSURANCE INFORMATION

Insurance Carrier: _____

Insured Person: SELF Other (name of person): _____

Insured ID: _____ Policy Group: _____

Secondary Coverage (if applicable): _____

RESPONSIBILITY FOR PAYMENT: I hereby acknowledge that copays and any portion of the charge for service(s) rendered or supplies provided by the physicians of Encompass Medical Group not covered by designated insurance carrier, Medicare, or guarantor agency will be my responsibility to pay in full.
AUTHORIZATION & ASSIGNMENT MEDICARE: I request that payment of authorized Medicare benefits otherwise payable to me, be made on my behalf to Encompass Medical Group, for any services or supplies furnished by me by that physician. I authorize Encompass Medical Group physicians and authorized personnel to release to the Health Care Financing Administration and its agents any medical information needed to determine benefits payable for related services or supplies.
INSURANCE: I hereby authorize Encompass Medical Group and its physicians to furnish or to receive from insurance companies and other health care providers any and all information concerning my medical or physical condition, diagnosis or treatment. I hereby assign payment or medical/surgical benefits to Encompass Medical Group, P.A. for medical services rendered, or supplies provided, to myself or my dependents.
PRIVACY: I received the Encompass Medical Group Notice of Privacy Practices.

My signature below indicates I have read and understand the above information:

Patient Signature: _____ Date: _____