GENESIS HEALTHCARE ASSOCIATES, P. C.

Please Print or Type

PRE-REGISTRATION INFORMATION

PATIENT NAME: LAST FIRST MIDDLE I	**SOCIAL SECURITY NUMBER DATE OF BIRTH SEX**
MAIDEN NAME LAST FIRST MIDDLE I	**EMPLOYER MARITAL STATUS**
STREET APT	**0CCUPATION**
CITY STATE ZIP	**STREET CITY**
HOME PHONE ( ) BUSINESS/DAYTIME PHONE ( ) EXT	**CELL PHONE ( ) STATE ZIP**
E-Mail Address	

PERSON RESPONSIBLE FOR BILL (OMIT IF SAME AS PATIENT INFORMATION)

LAST NAME FIRST MIDDLE	**RELATIONSHIP SOCIAL SECURITY NUMBER D.O.B.**
STREET APT	**EMPLOYER OCCUPATION**
CITY STATE ZIP	**STREET**
HOME PHONE: ( ) BUSINESS/DAYTIME PHONE: ( )	**CITY STATE ZIP**

EMERGENCY CONTACT – IF RESIDING AT A DIFFERENT ADDRESS (e.g. Friend or Relative)

LAST FIRST MIDDLE	**RELATIONSHIP**
STREET APT	HOME PHONE: ( )
CITY STATE ZIP	BUSINESS DAY/TIME PHONE: ( )

REFERRING PHYSICIAN

LAST FIRST MIDDLE	PHONE: ( )
STREET	CITY STATE: ZIP

FINANCIAL INFORMATION

PLEASE BRING INSURANCE CARDS, REFERRAL FORMS (HMO, POS, PPO) OR AUTHORIZATION TO BILL OR OTHER THIRD PARTY PAYOR

PRIMARY INSURANCE:

PRIMARY INSURANCE CARRIER NAME	**POLICY # GROUP #**	**COPAY PLAN TYPE (HMO/PPO)**
ADDRESS TO MAIL CLAIMS	**SUBSCRIBER'S NAME/D.O.B.**	**VERIF. OF BENEFITS PHONE**
CITY STATE ZIP	**SUBSCRIBER'S SOCIAL SECURITY NUMBER**	**PRECERTIFICATION PHONE**
BEGINNING DATE REFERRAL NO.	**PRECERTIFICATION N O.**	**PRIMARY CARE PHYSICIAN**

SECONDARY INSURANCE:

SECONDARY INSURANCE CARRIER NAME	POLICY # GROUP #	COPAY PLAN TYPE (HMO/PPO)
ADDRESS TO MAIL CLAIMS	SUBSCRIBER'S NAME/ D.O.B.	VERIF OF BENEFITS PHONE
CITY STATE ZIP	SUBSCRIBER'S SOCIAL SECURITY NUMBER	PRECERTIFICATION PHONE
BEGINNING DATE REFERRAL NO.	PRECERTIFICATION NUMBER	PRIMARY CARE P HYSICIAN

1. **FINANCIAL AGREEMENT**

I will inform GENESIS HEALTHCARE ASSOCIATES, PC of **EVERY** insurance policy which covers my child. This includes Medicaid or any other secondary insurance policy.

I agree to show my insurance card at each office visit and to pay my co-pay, deductible, or any non-covered service at the time of the visit. I understand that my insurance contract is between me and my insurance carrier. If I have questions regarding my coverage, or payment determinations, I will contact my insurance carrier directly.

I hereby assume full responsibility for all charges incurred for professional services rendered by Genesis Healthcare Associates, P.C., unless the services are deemed "paid in full" as a result of a contractual agreement between Genesis Healthcare Associates, P.C. and my insurer. If for any reason my health insurance coverage is no longer active at the time services are rendered by Genesis Healthcare, I understand that I am responsible for all charges for that office visit. I further understand that I am responsible for all balances my insurance carrier does not pay within 90 days.

If a check payment is returned on my account, I am aware that my account will be charged an additional **$75.00 fee.**
If I have an appointment for which I fail to show up, I understand that my account will be charged a **$25.00 fee.**
If I reschedule or cancel appointments with less than 24 hours' notice, I understand my account will be charged a **$25.00 fee.**
If my child has two insurance plans and I fail to inform Genesis Healthcare Associates, P.C. about the additional coverage, a **$100 administrative re-filing fee** will be charged to your account to reprocess the claims.

All unpaid balances on my account will be charged 3% interest monthly until paid in full. If my account is referred to an outside collection agency, I agree to pay my balance plus the collection agency fees. In the event a physician is requested for a court appearance, I am responsible for physician fees and court costs which are not paid by my attorney or representing parties.

Once your EOB determines that you are due a refund, you may call our office with your request. Genesis Healthcare Associates PC routinely processes refund requests the first week of each month. Refund checks are not completed at the office. A check will be mailed to your home after your request has been processed.

I have read and understand the financial policy above. I consent to the terms of the above policy and agree to be bound thereby.

2. AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Genesis Healthcare Associates, P.C. to release any medical, psychiatric, infectious disease (including AIDS confidential information) or drug and/or alcohol related information to my referring physician and any insurance company with whom I have medical benefits for the purposes of filing a medical claim. I acknowledge that this authorization is valid until such time as all medical bills related to my treatment have been paid. I further understand that I can withdraw this consent for release of information at any time prior to this expiration date except to the extent that action has been taken in reliance hereon.

3. GROUP AND INDIVIDIUAL INSURANCE ASSIGNMENT OF BENEFITS

I authorize my health insurance benefit plan to pay directly to Genesis Healthcare Associates, the medical benefits. If any, otherwise payable to me for their services as described on the attached claim but not to exceed the charges for those services. I understand I am financially responsible to Genesis Healthcare for charges not covered by this agreement.

4. MEDICARE, CLAIM AUTHORIZATION AND PAYMENT REQUEST

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

SIGNATURE: _____ DATE: _____

PLEASE COMPLETE REVERSE SIDE
- OVER –