PATIENT REGISTRATION FORM

PATIENT INFORMATION			**DR.:** □ **FARINACCI**	□ **GROSSMAN**	□ **KNOTEK**
Last Name	First	Middle	Relationship Status: Circle One Single / Married / Divorced / Separated / Widowed / Domestic Partnership		
Street Address	Apt. #		Date of Birth	Age	Home Phone # ( )
City	State	Zip	Social Security #		Cell Phone # ( )
Employer			Occupation		Work Phone # ( )
Employer Address			City	State	Zip
E-Mail Address					
Referred By			Address		Phone # ( )
Family Physician			Address		Phone # ( )
□ Please forward test results to the primary care doctor listed without a separate signed release _____(Initial)					
Emergency Contact Name			Relationship to Patient		Phone # ( )

PRIMARY INSURANCE INFORMATION				
Primary Health Insurance				
Subscriber's Name		Subscriber's SS **#**		Date of Birth
Policy/ID#		Group #		Relationship to Patient
Subscriber's Address	Apt. **#**	City	State Zip	Phone # ( )
Subscriber's Employer				Phone # ( )

SECONDARY INSURANCE INFORMATION				
Secondary Health Insurance				
Subscriber's Name		Subscriber's SS **#**		Date of Birth
Policy/ID#		Group #		Relationship to Patient
Subscriber's Address	Apt. **#**	City	State Zip	Phone # ( )
Subscriber's Employer				Phone # ( )

If insurance in another person's name, send bills: □ In my own name □ In name of insured

Lab Network Requirement? □ Quest Diagnostics □ Pathology Labs □ University Hospitals □ Cleveland Clinic

****PLEASE SEE THE REVERSE SIDE FOR OUR FINANCIAL POLICY****

Consent for assignment of benefits: I authorize the release of any information necessary to process insurance claims and to obtain reimbursement. I request that payment of authorized benefits be made on my behalf to South Suburban Women's Center. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the payment sources as required by my contract with my insurance plan. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred. I have read or have been advised to read the entire financial Policy on the reverse side.

_____ _____

Patient/Guardian Signature Date

Information Reviewed - Initials: _____□ 2019; _____□ 2020; _____□ 2021; _____□ 2022

South Suburban Women's Center

FINANCIAL POLICY

South Suburban Women's Center believes that communicating our financial policy is a good healthcare practice. Insurance coverage varies significantly among the many insurance carriers, therefore, it is your responsibility to read and understand the coverage and expectations of your particular insurance policy.

Charges incurred for services rendered are the patient's responsibility regardless of insurance coverage. Your insurance coverage is a contract between you and your insurance company, not your insurance company and us. South Suburban Women's Center will file your primary and secondary insurances only, as a courtesy. Please realize that having a secondary insurance does not necessarily mean that your services are covered at 100%. Secondary insurances typically pay according to a coordination of benefits with the primary insurance. It is your responsibility to provide us with accurate insurance information and to inform us of any changes in your coverage as they occur.

Co-pay, Co-insurance & Deductibles:

- **Co-pay: We are obligated to collect the co-pay at the time of your visit, even if you are sick. We are required to do so by your insurance plan. The co-payment amount is determined by your individual insurance policy.**
- **Deductible: Some insurance plans require that patients pay a pre-determined dollar amount prior to services being covered. This is the amount of money you must pay each year to cover your medical expenses before your health insurance policy starts paying.**
- **Co-insurance: Co-insurance is applied to the allowed charges from your insurance company normally after the deductible has been met. The co-insurance rate is usually expressed as a percentage. For example, if the insurance company pays 80% of the claim you are responsible for 20%. This portion is due at the time of service.**
- **At no time will co-pay, co-insurance, or deductibles be waived.**

Statements are sent out monthly, and payment is due upon receipt of your statement. Patient payments are typically applied to the oldest balances first, except for copayments and coinsurances – they are applied to the current date of service. There is a $35.00 returned check service charge payable within 5 days of notification. Payment will then need to be made by cash, money order, or credit card for the balance due and the service charge.

We realize that although most patients have health insurance, many do not. Because we are a private practice group, we do not receive the government funding that many hospitals or urgent care centers do. Patients who are self-pay will be required to pay for their office visit in full at the time of service. A discount will be applied to their charges.

Some patients may accrue large balances for services provided. For those patients with large balances, please contact a representative in our billing department at 216-581-9484 to set up a payment plan. **Please note: The minimum monthly payment amount is 10% of the initial balance or $25.00, whichever is greater.** Balances not paid in full within 90 days will be given a $50.00 late payment fee and turned over to an outside collection agency unless prior payment arrangements have been made. This will jeopardize having any future appointments with our office.

Completing insurance forms, FMLA forms, and other requested supplemental forms as well as copying medical records requires time away from patient care and day to day business operations. Prepayment of $10.00 per form is required. Please understand that in order to complete forms, your medical record must be reviewed, forms completed, and signed by the physician. We request that you allow at least 5 business days for this process.
