MEIER CLINICS® PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name:_____
(Last) (First) (Middle Initial) (Nickname)

Mailing Address:_____
(Street/PO Box) (Apt./Unit #) (City) (State) (Zip)

Home Phone:_____ Work Phone:_____ Ext. #:_____ Cell:_____

E-mail Address:_____

Social Security #:_____ Sex: ❒M ❒F Birth date:_____ Age:_____

Marital Status: ❒Single ❒Married ❒Divorced ❒Widowed ❒Other _____

Ethnicity: ❒American Indian/Alaskan Native ❒Asian ❒Black ❒Hispanic ❒White ❒Hawaiian/Pacific Islander ❒Other_____

Employer:_____ Occupation:_____ Student/School:_____ ❒Full-time ❒Part-time

If dependent child, are custodial parents: ❒Married ❒Separated ❒Divorced ❒Other_____

In Case of Emergency, notify: Name:_____ Relationship:_____

Address:_____ Phone:_____

Initial **ONE** only**:** _____ I hereby consent for Meier Clinics® to contact my PCP listed below, as deemed necessary, regarding my treatment. This consent shall remain in force during my treatment at Meier Clinics® and for 90 days following my last visit unless I expressly revoke it in writing.
_____ I do **not** want my PCP informed of my treatment at Meier Clinics® at this time.

Primary Care Physician:_____
(Name) (Address) (Phone)

FINANCIALLY RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Guarantor Name:_____ Birth date:_____
(Last) (First) (Middle Initial)

Guarantor Mailing Address:_____
(Street/PO Box) (Apt./Unit #) (City) (State) (Zip)

Guarantor Relationship to Patient: ❒Spouse ❒Mother ❒Father ❒Sibling ❒Other Relative_____ ❒Friend ❒Other_____

Home Phone:_____ Cell Phone:_____ Soc. Sec. #:_____

Guarantor's Employer:_____ Work Phone:_____ Occupation:_____

Address:_____
(Street/PO Box) (Unit #) (City) (State) (Zip)

INSURANCE INFORMATION

NOTE: Meier Clinics® ONLY bills insurance if your provider is contracted with your insurance plan. Fill the following out ONLY if this is the case.

Primary Insurance Co. Name:_____ Phone:_____

Subscriber's Name:_____ Relationship to Pt: ❒Self ❒Spouse ❒Parent ❒Other_____

Employer:_____ Phone:_____ Occupation:_____

Birth date:_____ Member ID #:_____ Group ID #:_____ Soc. Sec. #:_____

Secondary Insurance Co. Name:_____ Phone:_____

Subscriber's Name:_____ Relationship to Pt: ❒Self ❒Spouse ❒Parent ❒Other_____

Employer:_____ Phone:_____ Occupation:_____

Birth date:_____ Member ID #:_____ Group ID #:_____ Soc. Sec. #:_____

ASSIGNMENT OF BENEFITS: I hereby authorize and request my insurance to pay directly to Meier Clinics® the amount due for services rendered to me or my dependents. RELEASE OF INFORMATION: I authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for services rendered to me or my dependent. This consent is subject to revocation at any time, except where action has already been taken on the basis of this release. Unless revoked earlier, this release will be null and void six months after the final payment has been received on my account. This consent is subject to state and federal confidentiality requirements.

Insured's Signature:_____ Patient's or Guardian's Signature:_____ Date:_____

GUARANTOR AGREEMENT I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by Meier Clinics®. If the provider is contracted with the insurance company, I will be responsible only for the co-pay, co-insurance, deductible, and non-covered services as determined by the insurance plan.

Guarantor's Signature/Patient signature, if patient is guarantor:_____ Date:_____

TO BE COMPLETED ONLY BY STAFF Provider:_____ Appt:_____ Acct. #:_____

Comments:_____