Patient Registration

Please provide us with this important information for our records.

Patient's primary care physician _____ Today's Date____/____/____

Patient's last name _____ First name _____

Date of birth _____/_____/_____ Gender: ☐ Female ☐ Male ☐ Non-Binary ☐ Transgender ☐ Other

Home address _____

City _____ State _____ Zip code _____

Daytime contact number (_____) _____ Type ☐ home ☐ work ☐ cell

Evening contact number (_____) _____ Type ☐ home ☐ work ☐ cell

Email address _____ Primary Language _____

Preferred Communication ☐ Primary contact number ☐ Patient portal ☐ Mail

☐ Other (please describe):_____

Employer _____ Occupation _____

Employer address _____

Race ☐ African American ☐ White ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Decline to Answer

Ethnicity ☐ Hispanic, Latino, or Spanish origin ☐ Non -Hispanic, Latino, or Spanish origin ☐ Decline to Answer

How did you hear about us? ☐ Family/Friend ☐ Internet search ☐ Direct mail ☐ Social media ☐ Event

Insurance Information

Primary Insurance _____ ID # _____

Group #_____ Provider on Card _____

Insurance address _____

Policy holder name _____ Date of birth _____/_____/_____

Relationship to Patient _____

Employer _____ Employment status ☐ FT ☐ PT ☐ Student (FT or PT) ☐ Retired ☐ Not Employed

Secondary Insurance _____ ID # _____

Group #_____ Provider on Card _____

Insurance address _____

Policy holder name _____ Date of birth _____/_____/_____

Relationship to Patient _____

Employer _____ Employment status ☐ FT ☐ PT ☐ Student (FT or PT) ☐ Retired ☐ Not Employed

Hill health

Patient Registration

Patient name _____

Date of Birth _____/_____/_____

Emergency Contact

Name _____ Contact number (_____) _____

Relationship to Patient _____Date of birth _____/_____/_____

Acknowledgment

I understand that my privacy is protected and I have been given a copy of Hill Health, Inc., A Medical Corporation's Notice of Privacy Practices.

Signature _____ Print Name _____

Relationship to Patient _____Date of birth _____/_____/_____

Financial Responsibility and Consent for Medical Care

- I consent to receive medical care and treatment from Hill Health, Inc., A Medical Corporation.
- I have been offered Advance Directive information (not applicable for patients under 18).
- I acknowledge that acceptance of my insurance information is not a guarantee of payment by my health plan. I further understand that if my claim is not accepted for payment I am personally responsible for payment of medical services rendered to myself or a member of my family.
- I acknowledge that Hill Health, Inc., A Medical Corporation reserves the right to charge for appointments not canceled with 24 hours notice (up to $75.00).
- I acknowledge that all health plan deductibles and charges for non-covered benefits are due and payable within 30 days of presentation of a billing statement from the practice.
- I acknowledge that medical billing statements for services rendered by Hill Health, Inc., A Medical Corporation will be sent to the person who carries the insurance for the patient/family member.
- I acknowledge that I have read the above financial responsibility policies of Hill Health, Inc., A Medical Corporation and agree to abide by them.
- Assignment of insurance benefits – I assign all medical benefits to which I am entitled from private insurance and/or any other health plans, to the physician or Hill Health, Inc., A Medical Corporation. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I further authorize the release of any medical or other information necessary to process this claim.

Signature _____ **Print Name** _____

Relationship to Patient _____ **Date of birth** _____/_____/_____

For Office Use Only

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Reason _____

_____

Signature _____ Date _____/_____/_____