FOR OFFICE USE ONLY:

*Patient Name*_____

*MRN*_____

UNITED PHYSICIAN GROUP

Patient Registration Form

In an effort to maintain the most up-to-date records, you will be asked to complete this form annually.

Patient Information

Last Name:	First Name: M.I.:	Previous Name (if applicable)
Mailing Address: Apt #		
City/State/Zip:		
Home Phone:	Cell Phone:	Work Phone:
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) ☐ Voice ☐ Text		If Voice, Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work
Family Physician or Pediatrician:	Date of Birth:	Sex: ☐ Male ☐ Female ☐ Transgender
Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Other_____	Social Security #:	
Employment Status (Check al that apply): ☐ Employed ☐ Unemployed ☐ Student ☐ Disabled ☐ Other _____	Emergency Contact Name:	
Emergency Contact Phone #:		Relationship to Patient:

Responsible Party - If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor:

☐ **SAME AS PATIENT** or Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):

Email Address:

Race (select one):			Ethnicity (select one):
☐ White	☐ American Indian or Alaska Native	☐ Asian	☐ Hispanic or Latino
☐ Hispanic	☐ Black or African American	☐ Native Hawaiian or Pacific Islander	☐ Not Hispanic or Latino
☐ Other	☐ Decline		☐ Decline

Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil) ☐ Sign Language ☐ Spanish ☐ Russian ☐ Other

Do you require any accommodations? ☐ Deaf ☐ Blind ☐ Other _____

Medication Refills and Pharmacy

Please contact your pharmacy for medication refills. Your Pharmacy will fax us a medication refill request which the physician will review. Refill authorizations may require 48-72 hours. Please allow sufficient time for us to process your refill request. ***Initials***: _____

Preferred Pharmacy Name & Phone Number:

Referral Source:
☐ Word of Mouth ☐ Insurance Company ☐ Walk In ☐ Direct mail ☐ Web search ☐ Another physician/provider ☐ Other _____

Insurance Information

Please complete ALL SECTIONS for both primary and secondary insurance, as applicable. Failure to do so accurately could result in you receiving erroneous statements. Please provide a copy of all Insurance Cards and a Driver's License / Photo ID. You will be asked to present your insurance card(s) at each visit

Primary Medical Insurance	Secondary Medical Insurance
Type: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Other_____	Type: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Other_____
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:
For Worker's Comp ONLY- Date of Injury:	For Worker's Comp ONLY- Date of Injury:

Our office does NOT file Auto Insurance claims for visits relating to motor vehicle accidents.

☐ **I do not have insurance.**
Please initial here for acknowledgement and acceptance of our Self-Pay policies and pricing. ***Initials*: _____**

CONSENT FOR TREATMENT, RELEASE OF INFORMATION, AUTHORIZATION & ASSIGNMENT OF BENEFITS

I certify and acknowledge that the information I have provided is accurate and correct to the best of my knowledge. I consent to treatment necessary to the care which has been discussed with me and directed by the provider. I authorize the release of all medical records to specialists and/or consulting physicians, if applicable, to further my care.

I certify that I have read and agree to the United Physician Group (UPG) Financial and Billing policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby request, authorize and assign to UPG all money to which I am entitled for medical expenses related to the services performed from time to time by UPG, but not to exceed my indebtedness to UPG. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I authorize any holder of medical or other information about me to release to my insurance carrier or third party payer, the Social Security Administration, Health Care Financing Administration, its intermediaries, its carriers, or any other insurance carrier any information needed for this or any other related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment. I further understand that I am financially responsible for any co-pays, deductibles, and co-insurance due for test services if they are not reimbursed by my insurance. A $20.00 returned check fee will be charged for checks returned due to insufficient funds.

I hereby consent to credit bureau inquires and to receiving auto-dialed/artificial or pre-recorded message calls, and/or text messages and/or emails from UPG or its affiliates/agents including, without limitation, any account management companies, independent contractors or collections agents, including but not limited to communications about appointments, feedback, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party. Comments submitted on surveys may be anonymously shared on the UPG Public Website.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to UPG. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Primary Health Medical Group's Financial and Billing Policy. ☐ **(Initials)**

I have reviewed a copy of Primary Health Medical Group's Privacy Policy. ☐ **(Initials)**

Signature of Responsible Party X _____ Date: _____

Printed Name of Responsible Party: _____ Relationship to Patient: _____