Springhill Medical Group
Regristration Form

Patient Legal Name :			**Home Phone:**
Address:			Cell Phone :
City	State	Zip code	Work Phone:
SSN #	Sex: M or F		Marital Status: M S W D
Date of birth:	Drivers License #:		
Responsible Party **[**required if patient is a minor] - Emergency contact			
Name :			
Address:			
City	State	Zip code	Home phone:
Relationship: (circle) Spouse Parent Child Employer Child			Work Phone

********* **Insurance Information** *********

Primary Insurance Name:		
Policy holder/subscriber Full Name:		Birthdate:
SSN #	ID #	Group #

Secondary Insurance Name:		
Policy holder/Subscriber Full Name		Birthdate
SSN #	ID #	Group #

Employer Information (required if work comp)	
Employer Name	Phone :
Address :	**Contact person:**

Referring MD:	**PCP:**

Billing Policies/Assignment of Benefits:

The patients portion of all office services are payable at the time of service. Our office will assist the patient in obtaining reimbursement, however, delays or rejections are between the patient and their insurance company as the policy is a legal contract between the patient and the insurance company. The patient is financially responsible for all charges incurred. Any non-covered services are the financial responsibility of the patient. Springhill Medical Group accepts Medicare assignment. We will file claims as required by contract and as a courtesy to our patients. The patient or responsible party is ultimately responsible for payment of outstanding charges. Balances due must be paid upon receipt of the first statement. Checks, cash, and major credit cards are accepted. **There is a $51 fee for returned checks.**

Advance notification must be given for cancelled appointments at least one business day before the appointment;

I, the undersigned, authorize my insurance company/companies to direct payment for medical services rendered to myself or dependents directly to Springhill Medical Group. I hereby authorize the doctor release all information necessary to secure payment of benefits. I understand and agree to the above stated policies. This authorization and agreement shall be considered valid until revoked in writing.

Signature:	**Date:**
Relationship to patient:	SHMG staff :