PRO-HEALTH SERVICES PATIENT REGISTRATION

First Name: _____**MI:** _____ **Last Name:**_____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Birthday: _____ **Social Security Number:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____

Which Is The Best Number To Reach You At? Home Work Cell

Do You Give Us Permission To Leave A Message At This Phone Number? Yes No

Occupation: _____

E-Mail Address: _____

Sex: **Male** **Female**

Marital Status: Never Married Married Divorced Separated Widowed

Emergency Contact Name: _____

Telephone Number Of Emergency Contact: _____

I certify that the above information is true to the best of my knowledge.

Signature: _____ **Date** _____

PATIENT RIGHTS AND RESPONSIBILITIES

PATIENT RIGHTS

1. I have the right to expect quality medical care.

2. I have the right to receive my test results in a reasonable amount of time.

3. I have the right to have my medical care explained to me in a manner that I understand.

4. I have the right to be seen for medical services. However, I might not be a candidate for treatment depending on what I am being seen for. If I am under the age of 18, I will not be seen without written permission of my parent or legal guardian. If I am under the age 16, I cannot be left unaccompanied in the office.

5. I have the right to request a copy of my medical records. I must first sign a written release to receive this and there might be a charge for this service.

6. I have the right to privacy of my medical information and my care will not be discussed with anyone unless I have given written permission for this.

7. I have the right to be treated with dignity and respect.

8. I have the right to be notified and refuse in a visiting trainee or student wishes to participate in my care.

PATIENT RESPONSIBILITIES

1. I understand that payment in full is expected at the time of service. In the event I have an outstanding balance, no further appointments or services will be offered until this balance is paid in full.

2. Cash, VISA, Mastercard, Discover, American Express, and CareCredit are the accepted forms of payment. CHECKS ARE NOT ACCEPTED though debit cards are. CareCredit is only accepted for pre-paid weight loss programs of $1000 or more.

3. I understand 24 hours advanced notice is requested is I am unable to keep my appointment. Although some things do come up with short notice, if I do not give adequate notice, the office might not be able to offer my appointment time to another patient needing medical services. As a result, the office reserves the right to charge me $25.00-$75.00 for a missed appointment without sufficient prior notice.

4. I agree that for any professional liability claim I will follow binding arbitration. I realize that this may help decrease the cost of medical care in Ohio. By doing so, I am doing my part to help lower medical costs.

5. I understand that I am responsible for my health, complying with treatment and asking questions when appropriate.

6. I understand that for my physician to best serve me, I should call during business hours. Otherwise, the physician is unable to review my chart to advise me. In addition, I understand medications will only be refilled during normal business hours And prior authorizations will only be done when the office is open.

7. I understand that once services are rendered, refunds are not available. Any refund prior to services being rendered will be at the sole discretion of management.

I acknowledge my patient rights and agree to the above patient responsibilities.

_____ _____

Signature Date

FINANCIAL POLICY

In order for the office to be able to serve you, payment is expected in full at the time services are rendered. If there is an outstanding balance, services might not be able to be rendered. Angelice Alexander, MD is only a participating provider with Anthem Blue Cross Blue Shield, United Healthcare, and Optima insurances. If you are insured by one of these companies, you agree to assign your benefits to Angelice Alexander, MD. However, the office does not bill secondary insurance companies so these companies must be your primary insurance in order for Angelice Alexander, MD to accept assignment. Also, please note that these companies do not always cover all services rendered during a visit (ex: Body Composition Analysis, Medical Monitoring, Office Drug Testing, etc.). If you have a deductible, a payment will be required approximating what the insurance would dictate after adjudication. Until the office has in writing from the insurance company that a deductible has been met, you are responsible for making an approximate payment. If there is a deficiency after adjudication, this needs to be corrected promptly. If there is an overage, the difference will be refunded.

At your request, the office will bill other insurances as a courtesy unless the insurance company is Medicare, Medicaid or any other state-funded insurance. The insurance company might reimburse you but this is not guaranteed. Angelice Alexander, MD has opted-out of Medicare and so she is not a Medicare Provider.

If a test is ordered or labs are drawn, the third party provider (ex: LabCorp) will bill your insurance for these services. If you do not have insurance or if you do not provide a copy of your insurance card, the third party will bill you directly for these services. If you do have insurance and receive a bill, the provider did not receive your insurance information so simply contact the provider and give them your insurance information. If you do not have insurance, you might be able to pay the office directly in advance for these tests and obtain a discount.

Name Of Primary Insurance Cardholder
Birthday Of Primary Insurance Cardholder
ID Of Primacy Insurance Cardholder
Group Number of Primary Insurance Cardholder
Social Security Number Of Cardholder
Social Security Number For Patient

Once services are rendered, refunds are not available. Any refund is at the sole discretion of management. Please note that services might be rendered and an assessment might be done without a medication being prescribed.

Please let us know if you have any questions about the financial policy.

I acknowledge my rights as a patient, I agree to fulfill the patient responsibilities, and I agree to the financial policy.

Signature: _____ **Date:** _____