

Patient Registration Form

Please Print



Patient Information

New Patient

Name	Birth Date	Sex	SSN
Address	City	State	Zip
Home Phone	Cell Phone		
E-mail address	Marital Status S M D W		
Employer	Work Phone		
Spouse Name	Employer Phone	Cell Phone	
Emergency Contact If Other Than Spouse	Relationship	Home Phone	Work Phone

Primary Care Physician / Pharmacy Information

Primary Care Physician	Street, City	Phone
Pharmacy Name & Location	Street, City	Phone

Primary Insurance Information

Primary Insurance	Policy #	Group #
Subscriber Name	Birth Date	SSN
Relationship to Patient	Employer	Insurance Effective Date

Secondary Insurance Information

Secondary Insurance	Policy #	Group #
Subscriber Name	Birth Date	SSN
Relationship to Patient	Employer	Insurance Effective Date

Guarantor Information

(Person, if other than patient, financially responsible if insurance does not pay.)

Name	Birth Date	Sex	SSN
Address	City	State	Zip
Home Phone	Work Phone		
Employer	Employer Phone		

Form continues on back.

This document contains important information concerning your financial responsibility for services received at

The Counseling & Gynecology Group, P.C.

Financial Guidelines for Health Care Service

Please present your insurance card at every visit. As a courtesy to our patients we will bill a number of insurance companies directly. If we bill your insurance company, you will be responsible for any co-payment or deductibles. If you have an insurance plan other than those whom we bill directly, or if you are self-pay, payment is due and payable at the time services are rendered. If your insurance changes at any time, please notify us immediately. It is your responsibility to obtain a new referral (if required) and verify your benefits and acceptance of your insurance plan prior to services being rendered. Failure to do so may result in denied claims, which will then be your responsibility for payment. We have an obligation by contract with insurance companies to collect all co-pays at the time of service. We accept cash, check, MasterCard, and Visa. If you fail to pay your co-pay at the time of service, you will be charged \$10.00 for billing services. If you pay by check, and it is returned for any reason, it will be necessary to apply a \$25 returned check fee.

Primary Care Physician

It is important that you choose a primary care provider and establish a relationship with your physician and keep him/her informed of your medical history. Coordinate all your non-emergency care through your primary care provider and within your network of providers. If your insurance company requires a PCP to be chosen prior to receiving treatment, it is your responsibility to do so. If you fail to choose a PCP as required you may be held financially responsible. Standard Mass Health requires you to establish a relationship with a PCC. It is necessary for billing to have your referring MD PCC information. If you have not done this prior to your visit you may be denied services until such time you have established a PCC relationship; or you may self-pay at the time of service.

Referrals & Specialty Care

Your insurance plan may require prior authorization to be obtained for certain services in order to provide reimbursement. This often applies with plans that are out of the state of MA. Please contact your insurance company to determine referral requirements before receiving services. If the visit requires a referral, you are responsible for obtaining that referral through your primary care physician, or your insurance company, depending on your policy. You will be responsible for payment for services received without a referral.

Other Services, Laboratory & Pharmacy

Some insurance companies have identified specific laboratories, pharmacies, and/or X-ray providers they expect you to use. Please contact your insurance company to determine these arrangements. We will make every effort to assist you in obtaining these services from the preferred provider.

Non-covered Services

Please take time to read and understand the information provided to you by your insurance company including your member handbook. All insurance plans have limits on the services they cover and it is extremely important that you know your benefits, limitations and exclusions under your specific plan. If we bill your insurance and payment is denied, payment remains your responsibility.

Annual Physical Exam & Preventive Services

Many insurance companies classify the following as preventive services; annual exam, routine pap smear, cholesterol screening, urinalysis, diabetic screening and any other screening due to family history of disease. In the event that your insurance company does not cover preventive exams, services or other office visits without a referral; you will be responsible for these services. If this is a concern to you, please discuss this with our office manager or the billing staff before seeking medical care. Please do not ask us to resubmit claims with new codes if the claim was accurately submitted the first time.

Additional Fees

There may be fees for any of the following: A) special letter requests that are not within the normal scope of medical care for military, jury duty, work, or personal reasons that require a clinician's time; B) Duplicate prescription requests due to lost prescriptions; C) Copies of medical records for personal use and/or transfer of care; D) Re-billing of insurance claims due to your failure to present proper or current insurance information; E) Telephone management for a medical condition or modification to your treatment plan if you decline to come in for an available appointment.

Billing

Our billing service, PDQ Billing Services, is available to help you if you have any questions regarding your balance. They may be reached at 413-567-2258, Mon-Fri, from 8:30AM to 4:30PM. For questions regarding your policy, call the number located on your insurance card. I certify that the information given by me is correct. 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 have read the attached information and I understand that I am financially responsible for any account balance not paid by my insurance carrier.

Patient

Date

Parent or Guardian

Date