REGISTRATION AND FINANCIAL AGREEMENT – PINNACLE HEALTHCARE – PINNACLE MEDICAL GROUP

PATIENT DEMOGRAPHIC INFORMATION

NAME: ______________________ **DATE OF BIRTH:** ______________________ **SEX:** ☐ M ☐ F
ADDRESS: ______________________ **CITY:** ______________________ **STATE:** ______________________ **ZIP:** ______________________
HOME PHONE: ______________________ **CELL PHONE:** ______________________ **WORK PHONE:** ______________________
SOCIAL SECURITY NUMBER: ______________________ **EMAIL ADDRESS:** ______________________
PREFERRED PHARMACY (NAME, LOCATION, PHONE NUMBER): ______________________
RACE: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African-American ☐ More Than One Race ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Refused to Report/Unreported
ETHNICITY: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Refused to Report/Unreported **LANGUAGE:** ☐ English ☐ Spanish ☐ Other:

EMERGENCY CONTACT INFORMATION

NAME: ______________________ **RELATION:** ______________________
ADDRESS: ______________________ **CITY:** ______________________
STATE: __________ **ZIP:** __________ **PHONE:** ______________________

EMPLOYER INFORMATION OR PARENT/GUARDIAN

EMPLOYER OR GUARDIAN: ______________________
ADDRESS: ______________________ **CITY:** ______________________
STATE: ______________ **ZIP:** __________
**The following is for work related injuries ONLY*
***LENGTH OF EMPLOYMENT:** __________ ***JOB TITLE:** ______________ ***DATE OF INJURY:** __________

PRIMARY INSURANCE INFORMATION

INSURANCE: ______________________
ADDRESS: ______________________ **CITY:** ______________ **STATE:** ______ **ZIP:** __________
PHONE: ______________________ **SUBSCRIBER NAME:** ______________________
SUBSCRIBER SOCIAL SECURITY: ______________ **SUBSCRIBER EMPLOYER:** ______________________
SUBSCRIBER ID #: ______________________ **GROUP #:** ______________________
RELATIONSHIP TO SUBSCRIBER: ______________ **SUBSCRIBER DATE OF BIRTH:** ______________

SECONDARY INSURANCE INFORMATION

INSURANCE: ______________________
ADDRESS: ______________________ **CITY:** ______________ **STATE:** ______ **ZIP:** __________
PHONE: ______________________ **SUBSCRIBER NAME:** ______________________
SUBSCRIBER SOCIAL SECURITY: ______________ **SUBSCRIBER EMPLOYER:** ______________________
SUBSCRIBER ID #: ______________________ **GROUP #:** ______________________
RELATIONSHIP TO SUBSCRIBER: ______________ **SUBSCRIBER DATE OF BIRTH:** ______________

PLEASE INITIAL THE FOLLOWING STATEMENT IN ACKNOWLEDGMENT

☐ It is understood that this authorization for medical treatment and/or testing is given in advance for any specific diagnosis, treatment of emergency care or testing that may be required by the physician in the exercise of their best medical judgment.	☐ I understand that it is my responsibility to know the specific benefits of my insurance coverage. Insurance coverage is an agreement between myself and my insurance company. Therefore, it is my responsibility to make payment for non-covered services, including co-payments or co-insurance and deductibles. I hereby authorize the release of any pertinent medical information or records to the insurance carrier, if deemed necessary to process my medical claim.	☐ I hereby acknowledge that I have received a copy of Pinnacle HealthCare's notice of Privacy Practices. I further acknowledge that a copy of the current Privacy Practice notice is posted in the reception area, and that I will be offered a copy of any amended notice of Privacy Practice at each appointment.

FINANCIAL AGREEMENT - PATIENT AND PINNACLE HEALTHCARE - PINNACLE MEDICAL GROUP - **Financial Statement: Please initial each of the statements below prior to initiating medical services**

☐ I recognize that I am requesting treatment by Pinnacle Medical Group, dba Pinnacle HealthCare, and that I am responsible for any costs for that treatment, regardless of whether or not I have insurance coverage. I agree to promptly pay upon receipt, any statement for services rendered.

☐ I further agree that if any amount remains outstanding for a period of ninety (90) days, that balance will be considered to be delinquent and may be turned over to a collection agency, or an attorney for collection. If the account is turned over to a collection agency or an attorney for delinquency, I agree that in addition to the charges made by Pinnacle HealthCare for medical services, I will also pay the charge made by the collection agency [$25.00] and/or reasonable attorneys' fees and costs incurred collecting the unpaid balance of my account. You will be charged interest at 1% monthly or 12% annually on any unpaid balances. Return checks or credit card charge back will be charged a $35.00 service fee.

I have read and understand the entire Registration and Financial Agreement above. I have had the opportunity to have my questions answered in full and my signature below designates full acceptance of the policies, terms and expectations of services provided by Pinnacle HealthCare.

______________________	______________________	______________________	______________________
NAME (PLEASE PRINT)	**SIGNATURE**	**DATE**	**WITNESS**