

Patient Registration

Patient Information

Name: _____ Birthdate: ____/____/____ S.S.#: _____ - _____ - _____

Address: _____ Marital Status: _____

Home phone: (____) _____ - _____

City _____ State _____ Zip _____

Cell Phone: (____) _____ - _____

Employer Name: _____ Work phone: (____) _____ - _____

Address: _____

City _____ State _____ Zip _____

Spouse/Parent/Partner Information (If Student please give permanent address and phone # of parent or guardian.)

Name: _____ Birthdate: ____/____/____ S.S.#: _____ - _____ - _____

Work #: _____ Ext.: _____ Home #: _____

(Spouse's employer or Parent's address and employer)

Student: Full-time Part-time School: _____

Primary

Insurance Company _____ Subscriber: _____

(Primary insured person on the plan)

Pat-Subscriber relationship: _____ Subscriber Date of Birth: ____/____/____

(mother, father, husband, partner, self)

Member I.D.# : _____ Group #: _____

Secondary

Insurance Company _____ Subscriber: _____

(Primary insured person on the plan)

Pat-Subscriber relationship: _____ Subscriber Date of Birth: ____/____/____

(mother, father, husband, partner, self)

Member I.D.# : _____ Group #: _____

IN CASE OF AN EMERGENCY (relative or friend **NOT** living with you)

Contact: _____ Relationship: _____

Home #: (____) _____ - _____ Work #: (____) _____ - _____

Payment at the time of service is required in full unless you are insured by a contracted PPO or Medicare. **All deductibles, co-payments and services not covered by your plan are your responsibility at the time of service.** A finance charge of 0.83% per (10% annual rate) per California statute may be charged on all accounts over 60 days past due. There will be a \$10.00 delinquency fee for all accounts over 90 days. There will be a \$15.00 charge on all returned checks. Should collections be necessary, the patient shall pay all costs, including attorney's fees incurred in collecting payment for services performed under this agreement. A charge of \$50.00 for non-cancelled appointments.

Authorization: I hereby consent to any necessary medical treatment/physical examination required by the minor or myself named above for whom I am legally responsible.

Assignment: I permit payment directly to Robin Wedberg, M.D., for any benefits due to the Doctor for services rendered. I understand that I am financially responsible for all charges, whether or not covered by my insurance company.

Medical Records: Authorization is hereby granted for release of any information required to process this claim. A copy of this authorization is as valid as the original. Regardless of any claim pending, I will receive periodic statements if my account has an outstanding balance. Dr. Wedberg cannot accept responsibility for collection of my insurance claim if denied or for negotiating a settlement on a disputed claim.

I have read and agree to the above payment policy: _____ Date: _____

Signature