ALLEGHENY MEDICAL PRACTICE NETWORK
WEST PENN ALLEGHENY HEALTH SYSTEM

Patient Registration Form

IDX/GPMS Account Number _____

Billing Name — Responsible Party:
The section below refers to the PERSON / PARTY WHO SHOULD RECEIVE THE BILL

Relationship to Patient: ❑ Self (skip to next section) ❑ Parent ❑ Spouse ❑ Employer ❑ Other:_____

Billing First Name _____ M.I._____ Last Name _____

Address _____

City _____ State_____ Zip Code _____

Home Phone(_____) _____ DOB:_____ SSN:_____

Patient Information: This section refers to the PATIENT ONLY

Patient's First Name _____ M.I._____ Last Name _____

Address _____

City _____ State_____ Zip Code _____

Home Phone(_____) _____ Emergency Phone(_____) _____

Birth Date: Month_____Date_____Year_____ Sex: ❑ Female ❑ Male

Marital Status: ❑ S – Single ❑ M – Married ❑ D – Divorced ❑ W – Widowed

Social Security Number _____ Referring Physician _____

Employment Information: *(MUST BE COMPLETED)* Please check one: ❑ Employed ❑ Child ❑ DIS – Disabled
❑ PART – Part-time ❑ RET – Retired ❑ SELF – Self employed ❑ STU – Student ❑ UNEMP – Unemployed

If Employed, Employer Name _____

Employer Address _____

City _____ State_____ Zip Code _____

Work Phone(_____) _____ Ext._____

Please ensure the office has a copy of your most recent insurance card(s)
Please ensure the office has a copy of your current Driver's License

INSURANCE COVERAGE INFORMATION: Please show all numbers on your card(s).

Primary Insurance Information: ❑ No Insurance ❑ Medical ❑ Workers Comp. ❑ Auto Accident ❑ Liability

Insured (name on card) _____ Insured ID Number _____

Insurance Co. Name _____ Group/Member/Policy Number _____

Address _____ Effective Date _____

Co-payment Amount $_____

Primary Subscriber Information: This section refers to the PERSON IN WHOSE NAME THE INSURANCE IS LISTED

Relationship to Patient: ❑ Self (skip to next section) ❑ Parent ❑ Spouse ❑ Other: _____

Subscriber's First Name _____ M.I._____ Last Name _____

Address _____

City _____ State_____ Zip Code _____

Home Phone(_____) _____ Date of Birth_____Sex: ❑ Female ❑ Male

Social Security Number _____

Employment Information: *(MUST BE COMPLETED)* Please check one: ❑ Employed ❑ Child ❑ DIS – Disabled ❑ PART – Part-time ❑ RET – Retired ❑ SELF – Self employed ❑ STU – Student ❑ UNEMP – Unemployed

If Employed, Employer Name _____

Employer Address _____

City _____ State _____ Zip Code _____

Work Phone(_____) _____ Ext._____

Secondary Insurance Information: ❑ No Insurance ❑ Medical ❑ Workers Comp. ❑ Auto Accident ❑ Liability

Insured (name on card) _____ Insured ID Number _____

Insurance Co. Name _____ Group/Member/Policy Number _____

Address _____ Effective Date _____

Co-payment Amount $_____

Secondary Subscriber Information: This section refers to the PERSON IN WHOSE NAME THE INSURANCE IS LISTED

Relationship to Patient: ❑ Self (skip to next section) ❑ Parent ❑ Spouse ❑ Other: _____

Subscriber's First Name _____ M.I. _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone(_____) _____ Date of Birth_____Sex: ❑ Female ❑ Male

Social Security Number _____

Employment Information: *(MUST BE COMPLETED)* Please check one: ❑ Employed ❑ Child ❑ DIS – Disabled ❑ PART – Part-time ❑ RET – Retired ❑ SELF – Self employed ❑ STU – Student ❑ UNEMP – Unemployed

If Employed, Employer Name _____

Employer Address _____

City _____ State _____ Zip Code _____

Work Phone(_____) _____ Ext._____

Authorization to Pay Benefits to the Physician / Release of Medical Information

I hereby assign all medical and/or medical surgical benefits to include major medical benefits to which I am entitled to AMPN. I request payment of authorized benefits be made on my behalf to AMPN for any services furnished to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all allowed charges, non covered and/or co-payments whether or not paid by my insurance. I hereby authorize said assignees to release all information necessary for determination of benefits to my insurer or the Health Care Financing Administration. In the event that I am denied coverage, I will make arrangements to pay all bills within 30 days.

Date_____ Signature of Patient and/or Guardian if Patient is Minor _____

Medicare and Medigap Authorization

I request that payment of authorized Medicare benefits be made on my behalf to AMPN for any services furnished to me by that provider of service. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. This authorization will remain in effect until revoked by me in writing.

Date_____ Signature of Patient and/or Guardian if Patient is Minor _____

MEDIGAP I request that payment of authorized Medigap benefits be made on my behalf to AMPN for any services furnished to me by that provider of service. I authorize any holder of Medicare information about me to release to the secondary insurer listed above any information needed to determine these benefits payable services.

Date_____ Signature of Patient and/or Guardian if Patient is Minor _____

West Penn Allegheny Health System
Allegheny Medical Practice Network

CONSENT TO TREATMENT, PAYMENT AND ACKNOWLEDGEMENT

Patient Name:_____ Date of Birth:_____

Practice/Physician Name_____:_____

CONSENT TO TREATMENT

I request those physicians and other healthcare professionals who care for me to perform routine examinations, diagnostic procedures, hospital care and therapeutic treatments, which in their judgment, become necessary while I am being treated by the Physician Practice named above. Routine diagnostic procedures and medical treatments include but are not limited to ECGs, x-rays, physical therapy, blood tests and administration of medications. I also consent to medical photography necessary in the judgment of my physician, to document the course of my injury or illness and to provide appropriate medical care.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations. I authorize the Physician Practice named above to retain, preserve and use for scientific, or educational purposes, or dispose of at their convenience, any specimens or tissue taken from my body. If I undergo any procedure that requires the submission of tissue for pathologic examination, I authorize the use of any excess tissue for educational purposes.

I understand that the Physician Practice, in order to deliver quality healthcare, develops and maintains health information which may include physician notes, history and physical, medication reports, tests and test results, and treatment plans. I concur that this health information is used for the following:

- care and treatment plans
- billing statements
- communication between interdisciplinary healthcare providers
- verification of services by third party payers and government payers
- quality control by the Physician Practice

CONSENT TO APPEAL

In the event that my insurance company denies payment for my service, I authorize the Physician Practice to appeal for payment on my behalf; however, I understand that I have the right to rescind my consent to appeal at any time during the appeal process.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENT

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Physician Practice for any services furnished to me by that provider of service. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

STATEMENT TO PERMIT PAYMENT OF MEDICAID BENEFITS TO PROVIDER AND PHYSICIAN

I certify that the information given by me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Department of Public Welfare (D.P.W.) or its intermediaries or carriers any information needed for this or a related Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to D.P.W. for payment.

ASSIGNMENT OF INSURANCE OR PAYOR BENEFITS

I recognize that I am primarily liable for payment for services rendered. In the event that I am entitled to medical care benefits or insurance of any type whatsoever, I hereby assign those benefits and my rights to insurance payment to the Physician Practice named above and the appropriate health care providers to apply for benefits and insurance on my behalf for services rendered to me. I certify that the insurance or other coverage benefit information supplied by me is correct, in accordance with provider or insurance policies or agreements. If my insurance carrier requires pre-authorization for services I will receive, I understand that it is my responsibility to obtain the required pre-authorization. If I fail to do so, I will be liable for all or part of otherwise covered expenses.

ACKNOWLEDGEMENT OF RESPONSIBILITY FOR PAYMENT OF MEDICAL BILL

I guarantee payment of all charges incurred for services rendered by the Physician Practice named above for the Patient named above. The amount due for non-insurable charges including co-payment, deductibles, etc., shall be paid in full at the time of service. Should my account be referred to an attorney for collection, I agree to pay reasonable attorney's fees and collection expenses.

II. ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the West Penn Allegheny Health System Notice of Privacy Practices ("Notice"). I understand that information the Physician Practice named above acquires or creates about me will only be disclosed to others for treatment, payment and health care operations as set forth in the Notice or as authorized by me in writing.

I CERTIFY THAT I HAVE READ THIS FORM OR HAD IT READ TO ME AND UNDERSTAND ITS CONTENTS.

_____ _____

Signature Date/Time Witness Date/Time

_____ Patient _____ Substitute Decision Maker

_____ _____

If Substitute Decision Maker,state relationship If Substitute Decision Maker,state reason

West Penn Allegheny Health System
Allegheny Medical Practice Network
FINANCIAL POLICY

Thank you for choosing us as your health-care provider. The best medical care can be provided only on the basis of mutual understanding. We, therefore, encourage our patients to discuss any questions you may have regarding our policies. The following is a statement of our Financial Policy that we will require that you read and sign prior to any treatment.

FULL PAYMENT OF COPAYS THAT ARE REQUIRED BY YOUR INSURANCE COMPANY AND ANY PRIOR BALANCES ARE DUE AT THE TIME OF SERVICE

We accept Cash, Checks, Visa, Mastercard, American Express and Discover. If co-payments are not paid in full at the time of service and/or if satisfactory arrangements are not made to settle any prior balances, your visit may be rescheduled.

To avoid misunderstandings, the office manager invites early discussion of financial problems or questions regarding fees, payment plans and charity care.

INSURANCE

We accept insurance and we will submit a claim to your insurance company on your behalf. Insurance verification is required prior to your scheduled visit. Please be sure to have your insurance card available when requested. If your insurance can not be verified prior to your visit you will be registered as self pay. Payment in full, arrangements for a payment plan, or a charity care application is required at the time of service for all self pay patients.

Your insurance policy is a contract between you and your insurance company. It is important that you understand its' provisions. We can not guarantee payment of your claims. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanation will be made to you, their policy holder and it will be your responsibility to work with us to resolve the claim.

BILLING

A billing statement covering all outstanding medical services rendered will be mailed to you on a monthly basis. Charges and payments for services received during the last few days before your billing date may appear on the following monthly statement. If you have not paid your account in full after 90 days, or have not made regular monthly payments as agreed, we may turn your account over to a collection agency. In order to avoid any embarrassment, we strongly suggest that you do not let your account become delinquent.

CANCELLATION POLICY

Please help us serve you better by keeping your scheduled appointment. Notify us at least 24 hours in advance if unable to keep your scheduled appointment. Failure to show and /or notify us may jeopardize your next visit to our office. Also, a fee may be imposed.

WORKER' COMPENSATION

If you have a job related illness covered by Workers Compensation it is your responsibility to report your injury directly to your employer who will provide you with an authorization allowing us to treat you. You must inform us at the time of each visit that the visit is work related. You must also initially give us the name, address and phone number of your employer and the compensation insurance carrier along with the date of injury. If services are covered, payment will be accepted as payment in full. Please note you will be responsible for payment of services if all of the above information is not furnished.

AUTO INJURY

If you have been involved in a motor vehicle accident, it is your responsibility to report the injury directly to your insurance carrier. You will be responsible to provide us with the name, address and phone number of your insurance carrier and/or agent. Also, we will need the date of injury and claim number assigned by your insurance carrier. You must inform us at the time of each visit that the visit is related to the auto injury. If the services are covered, payment will be accepted as payment in full. Please note you will be responsible for payment of services if all of the above information is not furnished.

CHARITY CARE

We are committed to providing medical services to patients regardless of their ability to pay for these services. If you feel you have the need to ask for assistance in paying for your services, please request a Charity Care Application from the office staff. The need for Charity Care may be a sensitive and deeply personal issue. Please be assured that your request and the information you supply on the Application will be kept confidential.

Thank you for understanding our financial policy. Please let us know if you have any questions.

I have read all the information above and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

Signature M_____ Date_____

Responsible party_____ Date_____

Please print patient's name_____ Patient' DOB_____

Allegheny Medical Practice Network

INFLUENZA VACCINE AUTHORIZATION

I have read or have had explained to me the information regarding the influenza vaccine and had an opportunity to ask questions which were answered to my satisfaction.

I understand that if I have at least one of the health conditions listed below, my doctor will submit the claim to my insurance company as a courtesy. If I do not have one of the health conditions listed below, I must pay for the vaccine at the time of service.

Last name	First name	Initial	Birth date	Age	Sex

Address	City	State	Zip

Primary Insurance	Secondary Insurance	Daytime phone number

Health conditions
(Please check all that apply.)

[ ] Heart disease	[ ] Asthma	[ ] Kidney disease	[ ] Other (specify)
[ ] Anemia	[ ] Immunosupressed	[ ] Arthritis	
[ ] Diabetes	[ ] Lung disease	[ ] Health care worker	**[ ] None**

Doctor's name:

Signature of person to receive vaccine or person authorized to make request.	Date
X	
X Employee Number (if employed by WPAHS)	

FOR OFFICIAL USE ONLY

Date administered	Payment type	Payment amount

Route of administration

[ ] Intramuscular	[ ] Deltoid: (circle one) right or left	[ ] Thigh: (circle one) right or left

Lot # _____ **Expiration date:** _____	**VIS Form** _____ **Date** _____
Manufacturer:	

Signature of health care provider:	Date	Time AM PM