CRANMORE HEALTH PARTNERS
Primary, Pain, and Urgent Care

Patient Registration and Consent Form

Please provide demographics as follows:

Name (First, MI, Last): _____ Gender: ☐ Male ☐Female

Date of Birth: _____ Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Address: _____ City/Town:_____ State: _____ Zip Code: _____

Phone (home): _____ Phone (cell):_____ Work: _____

Primary Care Provider: _____ Pharmacy: _____

Preferred Language: ☐ English ☐ French ☐ Spanish ☐ Other: _____

Ethnicity: ☐ Non-Hispanic or Latino ☐ Hispanic or Latino ☐ Other: _____

Race: ☐ White ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ Native American ☐ Asian ☐ Other: _____

Emergency Contact:

Name:_____

Address: _____

_____

Phone: _____

Relationship: _____

We ask that you read through the financial policy and sign the bottom prior to treatment. Please provide our office with copies of your insurance cards.

Copays are due at the time of service. Full payment will be due at the time of service if the patient does not present insurance information. We accept cash or credit cards (Visa, Mastercard, and Discover.)

Our office will kindly bill your insurance company. We participate in a number of medical insurance plans that we may contact to verify eligibility and benefits. Please realize that you have the ultimate responsibility of verifying the coverage with your insurance. You acknowledge that we may be an out of network provider with your insurance. You are also aware that in some circumstances your insurer will send payment directly to you. You agree to endorse the insurance check and forward funds to the appropriate entity within 30 days of receipt. You will be responsible for any balance not paid or denied by your insurance carrier. Patients who do not supply accurate insurance information will be responsible for the balance. You must inform our office of any changes in your insurance, as you are the policyholder and it is your responsibility.

If your plan requires referral from your primary care provider, it is your responsibility to obtain this prior to seeking treatment from our office. If a claim is denied due to lack of referral, you will be responsible for the charges. You understand that you are financially responsible for claims denied or not covered by your insurance carrier if referral is not obtained.

If you are unable to keep your appointment, you must notify the office at least 24 hours prior to your scheduled appointment as a courtesy to the providers, staff, and other patients. If you cancel or "no show" without sufficient notice, you may be subject to a fee, payable by you, not your insurance company.

The above information is thorough and accurate to the best of my knowledge. Any changes to the above information will be communicated with the office. I consent to evaluation and treatment by this clinic. I hereby authorize the release of medical information that is necessary for treatment. I have read and agree to the above policy. I understand that payment is expected at the time services are rendered and that I am responsible for any balance.

Patient Signature: _____ Date: _____