GRANGER MEDICAL CLINIC

# Patient Registration

**Notification of Appointments/No Show** Thank you for respecting the time we have reserved for you. We invite you to mark the date of your future appointments on your calendar, and plan to arrive ten (10) minutes prior to the scheduled time. It is important to our business and the care of all patients that you inform us if you will not be able to attend your scheduled appointment, or if you believe that you will be late. In the event that you fail to provide at least twenty-four (24) hours of notice prior to canceling the appointment, arrive more than twenty (20) minutes late, or fail to arrive at all, the appointment will be considered a no-show and may result in a fee charged to your account. The standard no-show fee is $35 but may vary depending on appointment length or specialty. Recurrent no-shows may require a deposit to hold future appointments.

As a courtesy, you will receive a courtesy text, voice, and/or email reminder prior to your scheduled appointment. To make any changes to your upcoming appointment, please call the corresponding clinic's phone number which can be located on our website at www.grangermedical.com.

**Consent for Services** I hereby consent to medical treatment, diagnostic tests, imaging, laboratory, or other procedures which the health care provider(s) of Granger may consider or advise in the treatment of myself or those I'm responsible for. I agree, for Granger to service my account or to collect any amounts I may owe, Granger may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Granger may also contact me by sending text messages or e-mails, using any email address I provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

**Financial Agreement/Assignment of Benefits** I hereby authorize and request that payment of benefits by my insurance(s) be made directly to Granger for services for which I am responsible. I understand that I am financially responsible for all charges, including deductibles, co-insurance, copayments, and benefits services that are out of network, denied and/or not covered by my health insurance plan. I further understand that copayments are due at the time of service and that I am responsible for all charges not covered by this assignment. My signature requests that payment be made and authorizes release of any information necessary to process the claim(s).

In consideration of medical services rendered, I acknowledge that I have received this notice and agree to pay for said medical services. In the event any balance is not paid as agreed, I agree to pay a billing fee equal to the lesser amount of $40.00 or 30% of the unpaid balance for each claim not paid within 75 days from the first patient statement. In the event the unpaid balance is referred to a collection agency, I agree to pay a collection fee (up to 40% of the unpaid balance) and all costs of collection. In the event of a lawsuit to collect the unpaid balance, in addition to the above-referenced fees, I further agree to pay court costs and reasonable attorney fees.

**Release of Information** My signature authorizes Granger to release medical information that may be necessary to request claim reimbursement from insurance companies or other payers to whom claims have been submitted.

**Acknowledgement and Agreement**

- I acknowledge the Granger Financial Agreement and Assignment of Benefits and agree to all the terms and conditions contained therein.
- I acknowledge receipt of Granger's Notice of Privacy Practices.
- I have read this form, my questions have been answered, and I understand and agree to its content.

Patient or Guardian Signature _____ Date _____

Please continue to page 2.

GRANGER MEDICAL CLINIC

# Patient Registration

**Patient Information**

| First Name | Middle Name (or Initial) | Last Name | Preferred Name (Optional) | Date of Birth |
|---|---|---|---|---|
| | | | | |

| Street Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Primary Phone | Alternate Phone | Email | Preferred Contact: ☐ Call ☐ Text ☐ Email |
|---|---|---|---|
| | | | |

| Birth Sex: ☐ Male ☐ Female ☐ Other | Gender Identity: ☐ Male ☐ Female ☐ MTF ☐ FTM ☐ GQ ☐ Choose not to disclose | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor | Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Choose not to disclose |
|---|---|---|---|

Race: ☐ Asian ☐ Black ☐ White ☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Choose not to disclose ☐ Other

Would you like to be signed up to access the Patient Portal (Healow)? ☐ Yes ☐ No *[You must provide your email above]*

Do you have a Living Will or Advanced Directive? ☐ Yes ☐ No

**Emergency Contact**

| First Name | Last Name | Relation to Patient | Primary Phone | Alternate Phone |
|---|---|---|---|---|
| | | | | |

| Street Address | City | State | Zip |
|---|---|---|---|
| | | | |

**Provider / Pharmacy Information**

| Referring Provider | Phone | Primary Care Provider (PCP) | Phone |
|---|---|---|---|
| | | | |

| Preferred Pharmacy | Address | Phone |
|---|---|---|
| | | |

**Parent / Guardian Information (for minor patients only)**

| 1)Parent / Guardian Name | Date of Birth | Address | Phone |
|---|---|---|---|
| | | | |
| 2)Parent / Guardian Name | Date of Birth | Address | Phone |
| | | | |

**Responsible Party**

| First Name | Last Name | Phone | Relation to Patient |
|---|---|---|---|
| | | | |

**Insurance Information (if more than one, please request an additional form)**

| Primary Insurance (Name) | Subscriber Name | Date of Birth | Subscriber ID# |
|---|---|---|---|
| | | | |
| Group # | Claim Address | | Relation to Patient |
| | | | |
| Secondary Insurance (Name) | Subscriber Name | | Date of Birth |
| | | | |
| Group # | Claim Address | | Relation to Patient |
| | | | |