MIDDLETOWN VALLEY FAMILY MEDICINE

300 South Church Street
P.O. Box 20
Middletown, MD 21769
(301) 371-9000
(240) 566-7000 Fax

Patient Registration Form

Date: ___/___/_____

Preferred Provider:

Patient Information

Last Name: First Name: MI:

Date of Birth: Age: SSN:

Address:

City: State: Zip Code: Email:

Please check primary phone	Home Phone ☐	Cell Phone ☐	Work Phone ☐

Marital Status:
☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Life Partner

Gender:
☐ Male ☐ Female

Race:
☐ American Indian/Alaskan Native
☐ Black/African American ☐ Asian
☐ White/Caucasian ☐ Multiracial
☐ Refused/Undetermined
☐ Native Hawaiian or other Pacific Islander

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Refused or Undetermined

Primary Language:
☐ English
☐ Spanish
☐ American Sign Language
☐ Other

Occupation: Employer:

Primary Insurance Information ☐ *Check if same as patient*

Primary Insurance Name:

Name of Policy Holder: DOB: SSN:

Relationship to the Patient: Employer:

Policy #: Group #:

Secondary Insurance Information *(Only if Applicable)*

Secondary Insurance Name:

Name of Policy Holder: DOB: SSN:

Relationship to the patient: Employer:

Policy #: Group #:

In Case Of Emergency

Name of friend or relative: Relationship to patient: Home Phone: Cell Phone:

The information provided is true to the best of my knowledge. I understand that I am financially responsible for any charges not paid by my insurance. I agree to assign payments from my insurance company directly to Middletown Valley Family Medicine. I authorize Middletown Valley Family Medicine to provide my insurers with any information they may request. I agree to the financial policy of Middletown Valley Family Medicine and understand that I will be charged a monthly rebilling fee until my account is paid in full. I also agree that in the event that my account must be turned over to an agency for collection, I will be responsible for collection fees and any other associated costs. A photocopy of this assignment is considered to be as valid as the original.

Patient/Parent/Guardian Signature _____ *Today's Date* _____

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BILLING

Our office submits all claims to the insurance carrier you provide to us. We will continue to submit claims for all services we provide. Any co-payments required by an insurance company must be paid at the time of service. Failure to pay at the time of service will result in a billing penalty charge of $10.00 per missed co-payment. Please understand that there are services your insurance carrier may consider "non-covered". Our patients will be responsible for payment of these charges should your insurance carrier deny coverage.

Any returned check will be subject to a $25.00 charge. Pending balances will be billed to you with an additional $5.00 billing fee after your first notice. After three bills, the account will go to collections. We are willing to make payment arrangements with you.

Your insurance carrier defines an annual physical as a "routine evaluation and management service in the absence of patient complaints including history, physical examination, risk factor reduction intervention, and the ordering of laboratory/diagnostic procedures". If an illness or injury is discovered during an annual physical examination, an additional office visit code is to be billed. Your insurance company established this billing system following their reduction (by more than 50%) in payment for annual examinations. Therefore, you may find that we have billed your insurance carrier for a preventive visit as well as an additional visit on the same date of service.

Please notify our office if you are being treated for an automobile accident or worker's compensation related injuries. We will need the case number, carrier name, and claim address prior to your visit so that we may bill the insurance company. Payment in full will be required from you if the information is not provided at the time services are provided or if we do not receive payment from the insurance carrier within 45 days. INITIAL _____

APPOINTMENTS

Once an appointment has been made, please respect the time that has been reserved in our office schedule for you. We make every attempt to give our patients a courtesy call to remind you of your appointment time, however, it is your responsibility to make sure you have this information, so you do not miss your appointment.
We reserve the right to charge a fee for appointments broken or cancelled without advanced notice during regular business hours.
You will be charged as follows:
A regular appointment with a primary care provider without a 2-hour notice - $25.00
A complete physical appointment without a 24-hour notice - $100.00
A regular appointment with Dr. Adriana Hohl, our endocrinologist, without a 48-hour notice - $50.00
A consultation appointment with Dr. Adriana Hohl without a 48-hour notice - $100.00

INITIAL _____

REFERRALS

Your insurance company, not this office, establishes referral policies. **Please note that referrals require up to 48 hours to process**. When requesting a referral, please include your name, date of birth, insurance company name, insurance ID number, specialist name, specialty, and reason for visit. We will notify you when your referral is ready for pick up or we can send it to you via USPS Mail. We will automatically send it via facsimile or electronically to your specialist. Same day referrals are limited to medical emergencies. **WE DO NOT BACK DATE REFERRALS,** per your insurance and our office policies. If you are unsure whether your insurance plan requires referrals, please ask the front desk or you may call your insurance company.

INITIAL _____

PATIENT FORMS

There will be a $25.00 fee for all forms that are dropped off during unscheduled appointments. To be exempt from this charge you will need to schedule an appointment with a provider. INITIAL _____