# 2019 PATIENT REGISTRATION FORM

**Patient First Name**: _____ **Patient Last Name**: _____ **M.I.**: _____

**Date of Birth**: _____ **Social Security #**: _____ **Sex: M / F**

**HIPAA Disclosure Information: With whom do you allow us to share your personal medical information?**

*** Non-Clinical information is scheduling and appointment information only**.

| Name of Disclose | Relationship to Patient | Phone Number | Share Non-Clinical* Info | Share Clinical Info |
|---|---|---|---|---|
| | | | Yes □ No □ | Yes □ No □ |
| | | | Yes □ No □ | Yes □ No □ |

**Signature**: _____ **Date**: _____

With my signature, I am confirming that the information above is correct to the best of my knowledge. I also acknowledge that it is my responsibility to alert Starling of any changes to my HIPAA information.

**Patient Demographics**

**Primary Language**: _____ **Marital Status (S/M/W/D)**: _____

**Race** (circle one): Black/African American Asian White American Indian Declined Other_____

**Ethnicity** (circle one): Hispanic/Latino Non-Hispanic/Latino Declined **Advance Directive/Living Will**: Yes □ No □

**Mailing Address**: _____

**APT/Unit**: _____ | **City, State, Zip**: _____ | **Minor** *(if under 18)*: □

**Employer Name:**_____ **Employer Phone:( )**_____

**Employer Address:**_____

**Please note: As a service to our patients, Starling Physicians, P.C. uses an automated confirmation service to remind you of your appointment. In the event the call is not answered, a message is left.**

**Provide all methods of contact on lines below and check the box next to your preferred method for automated appointment confirmations:**

**For other calls: May we leave a message regarding your medical care or test results?** □ Yes □No

□ Home Phone: _____ *□ Cell Phone (circle option: Text Call) _____

□ Work Phone: _____ □ Email Address: _____

□ I would prefer **not** to have an automated reminder.

□ I already receive reminders via Follow My Health

*Approval of this preferred method of contact acknowledges that you are aware of and will accept any **usage charges** that may apply from your cell phone carrier.

**PLEASE TURN PAGE OVER** 

## Insurance Information

*Primary*| **Insurance Co.** _____

**Policy #**: _____ | **Group #**:_____

**Effective Date of Insurance**: _____

*Primary Subscriber*| **Name**: _____

**D.O.B.**: _____ | **Relationship**: _____

*Secondary*| **Insurance Co**: _____

**Policy #**: _____ | **Group #**:_____

**Effective Date of Insurance**: _____

*Secondary Subscriber*| **Name**: _____

**D.O.B.**: _____ | **Relationship**: _____

## Additional Information ( Skip this Section if you are Registering for Primary Care, Family Practice or Pediatrics)

**Primary Care Physician** (Name): _____ **Phone**: (  )_____

**Address** (PCP): _____ **Referring Provider** (Name): _____

**Address** (Referring Provider): _____ **Check here if Self-Referred**: □

## Emergency Contact Information: Who can we call in case of an emergency?

| Emergency Contact Name | Relationship | Phone Number | Leave Message | Message Type |
|---|---|---|---|---|
| | | | Yes □ No □ | Detailed □ Brief □ |

## For Medicare Patients

I request that payment of authorized Medicare benefits be made on my behalf to Starling Physicians, P.C. for any service provided to me by that physician. I authorize any holder of medical information about me be released to the Health Care Financing Administration and its agents including any information needed to determine those benefits or the benefits payable for related services.

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## Missed Appointment Policy

Please be advised that Starling Physicians, P.C. reserves the right to charge for missed appointments. If you do not keep your appointment and have not called to cancel or reschedule 24-hours prior to the scheduled appointment, a charge may be applied to your account.

## Payment and Patient Responsibility Policy

Please be advised that, under your insurance contract, you are responsible for your co-payment, coinsurance or deductible. It is the policy of Starling Physicians, P.C. to collect all co-copayments due at the time of service. Additionally, it will be requested that you pay any outstanding balance at the time of service. If required by insurance, patient is responsible for obtaining a referral or an authorization prior to their scheduled appointment.

## Authorization and Release

I hereby authorize payment directly to Starling Physicians, P.C. of medical benefits otherwise payable to me. I understand I am financially responsible for charges not covered by assignment. I hereby authorize Starling Physicians, P.C. to release information requested to support my claim.

**By signing, you acknowledge that you have been informed of and agree to the terms of these policies**

**Signature:**_____**Date:**_____

**We would like to receive your feedback, regarding your visits to Starling. Please provide your email address below if you would like to share your experiences, regarding our services, in the form of a patient survey**

**Email:**_____**Date:**_____

**PLEASE TURN PAGE OVER** 