2021 PATIENT REGISTRATION FORM

First Name: _____ Last Name: _____ Date of Birth: _____ 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 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 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 put check mark 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)

__ 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 Ins. 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.

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 canceled or rescheduled 24-hours prior to the appointment, a charge may be applied to your account.

Payment and 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-payments 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 feedback, regarding your visits to Starling. Please provide your email address below if you would like to share your experiences, regarding our services, in a form of a patient survey.

Email: _____ Date: _____

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