

REGISTRATION FORM-----WELCOME TO OUR OFFICE

PATIENT'S NAME		SOCIAL SECURITY NUMBER		SEX: MALE FEMALE	DATE OF BIRTH
MAILING ADDRESS		CITY	STATE	ZIP CODE	HOME PHONE # WORK PHONE #
PATIENT'S EMPLOYER		EMPLOYER'S ADDRESS		PATIENT'S OCCUPATION	
SPOUSE OR PARENT'S NAME		SOCIAL SECURITY NUMBER		DATE OF BIRTH	SPOUSE OR PARENT'S OCCUPATION
ADDRESS, IF NOT THE SAME AS PATIENT'S		CITY	STATE	ZIP CODE	HOME PHONE #
SPOUSE OR PARENT'S EMPLOYER		EMPLOYER'S ADDRESS		WORK PHONE #	
PRIMARY CARE PHYSICIAN					
WHO REFERRED YOU TO OUR OFFICE?					

**WHO SHOULD WE CONTACT IN CASE OF EMERGENCY?
PLEASE LIST TWO CONTACTS IN ADDITION TO THE SPOUSE OR PARENT LISTED ABOVE.**

NAME		RELATIONSHIP TO PATIENT		HOME PHONE #
MAILING ADDRESS		CITY	STATE	ZIP CODE WORK PHONE #
NAME		RELATIONSHIP TO PATIENT		HOME PHONE #
MAILING ADDRESS		CITY	STATE	ZIP CODE WORK PHONE #

PLEASE FILL OUT THE FOLLOWING INSURANCE INFORMATION. ALL CHARGES ARE DUE AT TIME OF SERVICE.

PERSON RESPONSIBLE FOR PAYMENT		RELATIONSHIP TO PATIENT		HOME PHONE #
MAILING ADDRESS		CITY	STATE	ZIP CODE WORK PHONE #

PLEASE READ AND SIGN THE INSURANCE AND TREATMENT AUTHORIZATIONS ON THE REVERSE

TREATMENT CONSENT FOR MINORS (To be completed by parent or guardian if patient is under 18 years of age):

I state that I am the legal guardian of this patient. I authorize Dr. Joseph McKinlay and/or medical staff under his direction to render medical care even if I cannot be present. I also understand that I will be responsible to pay any bills that are incurred as a result of the visits.

SIGNATURE OF PARENT OR GUARDIAN

RELATIONSHIP TO PATIENT

DATE

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS:

I hereby authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare/Other Insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of authorized Medicare/other Insurance company benefits be made to Joseph R. McKinlay, M.D. who accepts assignment on all Medicare Claims. Regulations pertaining to Medicare assignment of benefits apply.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare/Other Insurance company assigned cases, the physician agrees to accept the charge determination of the Medicare/Other Insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/Other Insurance company. I understand that I am financially responsible for all charges incurred. I also understand that if my insurance requires a written referral or pre-authorization from my primary care physician in order to pay benefits, I am responsible to ensure that one is provided before the visit occurs (even if Dr. McKinlay's receptionist schedules an appointment with Dr. McKinlay for me), or I will be liable for the full charges incurred. Dr. McKinlay DOES NOT PARTICIPATE with any of the Medicare HMO plans! I further acknowledge that my insurance benefits, when received by and paid to Dr. McKinlay, will be credited to my account in accordance with the above agreement.

All charges will become the patient's financial responsibility if your insurance carrier has not paid within 60 days.

If I have Medigap coverage, I request authorized Medigap benefits to be made on my behalf to Joseph R. McKinlay, M.D. for any services furnished to me. I authorize any holder of medical information to release to my Medigap carrier any information needed to determine these benefits or the benefits payable to related services.

I have been notified that Dr. McKinlay does not fill out or file any workers' compensation paperwork. I am responsible for full payment for services rendered by Dr. McKinlay even if my skin condition is work-related.

SIGNATURE OF PATIENT
(OR GUARDIAN IF PATIENT IS UNDER 18)

RELATIONSHIP TO PATIENT
(IF SIGNED BY SOMEONE OTHER THAN PATIENT)

DATE