

# STATCare Plus Registration Form

**\*Please provide the Receptionist with your Insurance Card and Photo ID\***

**Patient Information** Today's Date: \_\_\_\_\_ SS# \_\_\_\_\_

Name: \_\_\_\_\_ Sex: M F  
Last First MI Name patient prefers to be called Circle

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Marital Status: \_\_\_\_\_

\*Race: \_\_\_\_\_ \*Ethnicity: \_\_\_\_\_ \*Federal Law requires clinics utilizing Electronic Health Records ask these questions.

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ May we text appointment reminders? \_\_\_\_\_

Employer \_\_\_\_\_ E-mail address \_\_\_\_\_

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## Responsible Party

Name: \_\_\_\_\_ Sex: M F SS# \_\_\_\_\_  
Last First MI Circle

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer: \_\_\_\_\_  
Company Name Address City State Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

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## Insured Party

Name: \_\_\_\_\_ Sex: M F SS# \_\_\_\_\_  
Last First MI Circle

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

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**Emergency Contact Name:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**HIPAA INFORMATION**

I authorize the staff of STATCare Plus to discuss my medical or payment information with the following persons. This authorization shall remain in effect until such time as it is withdrawn by me in writing.

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

**FINANCIAL INFORMATION**

If we are a provider for your insurance, we will submit your claim to your insurance company. You are responsible for your co-pay and/or portion that your insurance company requires on the date services are rendered. The amount collected at time of service is an estimate only. You may receive a bill for the remainder amount that the insurance does not pay. Payment not received within 60 days of filing your insurance becomes patient responsibility. *If we are not a provider for your insurance company we will file your insurance as a courtesy; however, all charges are due at time of service. If you have no insurance all charges are due at time of service. IT IS YOUR RESPONSIBILITY TO INFORM US OF ANY CHANGES REGARDING YOUR INSURANCE.*

Liability insurance claims and athletic insurance claims must be paid on date of service and reimbursed to you by the responsible company. It is your responsibility to file these claims.

Workers' Compensation Claims and any other procedures paid by your company must be approved in advance of the visit by the company who is responsible for the claim. If we are unable to obtain an approval in advance of the visit you will be responsible for all charges at time of service. Upon approval, any amount paid by the patient will be reimbursed.

The parent of a minor child bringing the child to the clinic for treatment, or authorizing treatment of the child, is the responsible party for any financial obligations incurred as a result of the treatment. We will not bill another party for the child's treatment.

If you have a returned check, a \$40.00 returned check fee will be added to your account.

No show fees of \$40.00 will be added to your account should you fail to notify us in advance of the need to change or cancel an appointment.

**FAILURE TO PAY AMOUNT DUE BY YOU AT TIME OF SERVICE WILL RESULT IN A \$15.00 SERVICE CHARGE ADDED TO YOUR BILL.**

We reserve the right to refuse service due to improper conduct, harassment or unpaid bills that are patient responsibility.

**I have read and fully understand the above policies. I understand that this does not guarantee insurance payment or the denial of insurance payment. It is understood that only my insurance company or companies can make that determination. I consent to the assignment of authorized health insurance benefits by my health insurer to STATCare Plus for any services furnished to me or my dependents. I further understand that I will be responsible for any court costs, attorney fees or interest that may be incurred if I should fail to pay all balances due upon receipt of billed charges.**

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

**I, the undersigned, consent to the care and treatment by the attending provider, his/her associates or assistants. I acknowledge that no guarantees have been made as to the effect of such treatment.**

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

**I, the undersigned, do hereby acknowledge receipt of STATCare Plus's Privacy Notice.**

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

