

PLEASE PRINT

٦.	TICVETA	TOT	ISHED	TAAPT	ABAN ALBA
п	HOLA	KI	INHHII	PAI	HINI
4.	LATIT		ALTE BE AL.	LINE	

TODAY'S DATE: PATIENT CHART NO:					
PATIENT'S NAME:					
□ MALE □ FEMALE □ SINGLE □ MARRIED □ DIVORCED EMAIL					
RACE: AFRICAN AMERICAN ASIAN CAUCASIAN/WHITE DECLINED UNKNOWN NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER AMERICAN INDIAN/ALASKA NATIVE					
PRIMARY LANGUAGE: DENGLISH DEN					
ETHNICITY: HISPANIC NON-HISPANIC DECLINED UNKNOWN					
CURRENT ADDRESS:					
CITY: STATE: ZIP CODE:					
HOME PHONE: WORK PHONE:					
MERGENCY PHONE: DATE OF BIRTH:					
SOCIAL SECURITY NUMBER:					
PRIMARY INSURANCE NAME:					
SECONDARY INSURANCE NAME:					
DOES THIS INSURANCE REPLACE YOUR CURRENT POLICY?					
NAME OF THE SUBSCRIBER:					
RELATIONSHIP TO THE PATIENT:					
SUBSCRIBER DATE OF BIRTH: SUBSCRIBER S.S.N.:					
EFFECTIVE DATE OF POLICY:					
EMPLOYER OF SUBSCRIBER: PHONE #:					
EMPLOYER ADDRESS:					
OFFICE USE ONLY					
DOES THE PATIENT HAVE AN OUTSTANDING BALANCE?					
Time of appointment: Time signed in: Time given paperwork:					
Time paperwork returned: Time registration began: Time registration completed:					
Insurance Verified:					



Huntsville

FINANCIAL ARRANGEMENTS AND INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we would like to help you receive your maximum allowable benefits. In order to achieve this, we need your assistance and your understanding of our payment policy.

Payment is due at the time services are rendered unless payment arrangements have been approved in advance by our business office. We accept cash, checks, MasterCard and Visa. We will be happy to help you process your insurance claim. Changes in insurance data should be directed to our insurance clerks. In most instances, we will accept assignment of primary and secondary insurance benefits.

However, you must realize:

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
- Our fees fall within the acceptable range by most insurance companies and therefore should be covered to the maximum allowance determined by each carrier.
- Some services may not be covered by your insurance contract and you may be responsible for payment of those charges.
- 4. We may need to release medical information concerning you to your insurance carrier as part of the processing of your claim. By signing this form, you consent to the release of such information for that limited purpose.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. All co-pays are due at time of service. There is a fee for returned checks.

Past due accounts will be turned over to an agency for collection unless payment arrangements have been made with the business office. During that time, your future status with the clinic will be considered.

By signing this form, you accept responsibility for reasonable costs incurred if your account becomes past due and is referred to a collection agency. This cost includes attorney's fees and interst generated.

We value you as a patient and will continue to provide you with our best professional care.

If you have any questions about the above information, please do not hesitate to ask us. We are here to help you.

Date:	Signature:
-------	------------

The University of Alabama at Birmingham
UAB Health Center Huntsville • 301 Governors Drive, S.W.
Huntsville, Alabama 35801 • (256) 536-5511 • FAX (256) 551-4626