□ NEW PATIENT □ ESTABLISHED PATIENT

**PLEASE PRINT**

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: □ ENGLISH □ SPANISH □ OTHER: _____

ETHNICITY: □ HISPANIC □ NON-HISPANIC □ DECLINED □ UNKNOWN

CURRENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____

EMERGENCY PHONE: _____ DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

PRIMARY INSURANCE NAME: _____

SECONDARY INSURANCE NAME: _____

DOES THIS INSURANCE REPLACE YOUR CURRENT POLICY? □ YES □ NO
IS THE PATIENT THE SUBSCRIBER OF THE POLICY? □ YES □ NO
**IF NO, SUBSCRIBER INFORMATION REQUIRED BELOW:**

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? □ YES □ NO

Time of appointment: _____ Time signed in: _____ Time given paperwork: _____

Time paperwork returned: _____ Time registration began: _____ Time registration completed: _____

Insurance Verified: _____

## PATIENT INFORMATION SHEET
## MINOR CHILD

Patient Name _____ Birthday _____ Sex _____
Address _____ S.S.# _____
City _____ State _____ Zip _____ Home Phone _____

Father's Name _____ Home Phone _____
Father's Address _____ S.S.# _____
City _____ State _____ Zip _____
Father's Employer _____ Work Phone _____
Position Held _____ How long _____

Mother's Name _____ Home Phone _____
Mother's Address _____ S.S.# _____
City _____ State _____ Zip _____
Mother's Employer _____ Work Phone _____
Position Held _____ How long _____

## MEDICAL INSURANCE INFORMATION

Primary Insurance Company _____ Contract # _____ Group # _____
Name of Insured _____ Relationship to Patient _____

Secondary Insurance Company _____ Contract # _____ Group # _____
Name of Insured _____ Relationship to Patient _____

**AUTHORIZATION TO RELEASE INFORMATION:** The undersigned authorizes the Medical Practice to release any medical or other information about the patient which may be necessary for the proper filing of all insurance claims, review of services or receipt of benefits.

**ASSIGNMENT OF BENEFITS:** The undersigned assigns to and authorizes direct payment of benefits to the Medical Practice. The undersigned also agrees to assist in processing all claims for benefits.

**FINANCIAL RESPONSIBILITY:** The Medical Practice strives to provide the best possible medical care for its patients. We expect that we will be paid for the services rendered. The undersigned agrees to be totally responsible for all charges for services rendered to the patient, including any non-covered charges. The undersigned also agrees that if the unpaid account is referred to an attorney for collection, to pay all costs of collections, including reasonable attorney fees.

_____ _____
Parent / Guardian Guarantor

UAB HEALTH CENTER

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:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2. Our fees fall within the acceptable range by most insurance companies and therefore should be covered to the maximum allowance determined by each carrier.

3. 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