SFP Patient Registration Form

Patients Last Name: ___________________________First: ____________________Middle ______

Street Address: ____

City:__________________________________State:____________________Zip:______________

Primary Phone No.________________________ Secondary Phone________________________

Cell Number.______________________ DOB______/_____/_______ Sex: _____M _____F

Marital Status: S, M, D, W, Social Security Number _________/_______/__________

Email Address: ____

Patient's Occupation:_____________________EmployersName:__________________________

Employers Address/Phone Number: ____

In Emergency Name of Person to Notify: ____

Address:____Phone:________________________

If we are filing with your insurance company please complete the following:

Guarantor Name:____DOB__________
Phone Number______________________SocialSecurityNo.______________________________

How did you learn about our office?____Friend ____T.V. ____School ____Drive by ____Other

- ☐ I consent to treatment for the above named patient.
- ☐ I understand it is my responsibility to call the office for test results if I have not received a communication.
- ☐ For HMO patients, Dr. John Y. Shih must be listed as your Primary Care Physician.
- ☐ Otherwise, payment is due at the time of service.
- ☐ Co-Pay's and Deductibles are due at the time of service.
- ☐ Payment for services considered 'non-covered" are your responsibility payable within 30 days.
- ☐ An office visit charge for non-insured patients will be collected before services are rendered.
- ☐ Suwanee Family Physicians is unable to extend credit or set up payment plans.
- ☐ Accounts with balances over 60 days will be assessed a 30% fee and sent to collections.
- ☐ There is a $25.00 fee for bounced checks.
- ☐ Your benefits are an agreement between you and your insurance company. If your services are not covered by your insurance company, you are responsible for the balance.

Patient Int:_________

<u>Privacy Policy</u>: I authorize Suwanee Family Physicians to discuss my treatment, care, or financial responsibilities with the following person:____
Designate someone other than yourself.

Signature:____ Date:______________________

<u>Or:</u>
I do not authorize Suwanee Family Physicians to discuss my treatment, care, or financial responsibilities with anyone other than myself.

Signature:_______________________________________ Date:______________________