MEDICARE PATIENT REGISTRATION FORM

Name: _____ Jr /Sr
First Middle Last (how you wish to be addressed)

Local Address: _____
Street City State Zip Code

Other Address: _____
Street City State Zip Code

Local Phone: ( )_____ Other Phone: ( ) _____

Cell Phone: ( )_____

Social Security #: _____ Date of Birth: _____ Age: ____ Sex: ___ M ___ F

Name of Spouse Or Friend: _____ Phone Number: _____

Do we have your permission to:

Leave a message on your answering machine at home? Y _____ N _____
Leave a message at your place of employment? Y _____ N _____
Discuss your medical condition with any member of your household? Y _____ N _____

If yes, whom: _____ Relationship _____

_____ Relationship _____

Office / Billing Policy: We will file your charges to Medicare and the supplemental insurance. If you do not have supplemental insurance, you will be responsible for 20% of the charges at the time of the visit. You will also be responsible for your **2013 Medicare annual deductible of $147.00**. All returned checks are subject to a $30 handling fee.

Medicare Lifetime Authorization: I authorize Dr. King to release to the Social Security Administration and Center for Medicare and Medicaid Services or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance be made to Daniel King, MD. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____
Insured Signature Date

Supplemental Insurance Authorization: I request authorized insurance benefits be made to Daniel King, MD on my behalf for any services furnished to me. I authorized Dr. King to release to the attached insurance carrier any information needed to determine benefits. If payment is not received from the insurance company within 60 day, the account balance will be your responsibility.

_____ _____
Insured Signature Date

I hereby authorize Daniel King, MD to request medical records, pathology reports and laboratory reports from any physician, hospital, or clinic where I have been treated. I also authorize Daniel King, MD to release any medical records, pathology reports, and laboratory reports to any physician, hospital or clinic if requested. I authorize the release of my medical records or other information necessary to process an insurance claim.

_____ _____
Signature Date

We want you to know that, if you pass out, are disoriented or we feel it is an emergency we will call 911. This is for your safety. By signing below I acknowledge I have read and agree with the above

_____ _____
Signature Date