Randy D. Walker, M.D., P.L.L.C.

Kelly Hardin, A.N.P.

Family Practice & Allergy

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PATIENT REGISTRATION INFORMATION

Last Name: _____ Suffix: _____

First Name:_____ MI:_____

Address Line 1: _____

Address Line 2: _____

City: _____

State:_____ Zip:_____Country:_____

Email Address:_____

(Required in order to access the Patient Portal on-line)

Home Phone: _____

Cell No.: _____

Work Phone:_____Ext. _____

Date of Birth (mm/dd/yyyy): _____

Age:_____ Sex:_____ Race:_____

Ethnicity:_____ Language:_____

Marital Status:_____

Social Security #: _____

Employer Name:_____

PREFERRED METHOD OF CONTACT

Do you prefer to be reminded about appointment via home or cell phone? _____

Text or Voice Message? _____

Preferred Language: O English O Spanish

Preferred Time to Call: O Morning O Afternoon O Evening

Please list individuals whom we may communicate with about your care, referrals or payment for your care:

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

RESPONSIBLE PARTY (if minor)

(statements will be addressed to responsible party)

Name: _____

Address:_____

City: _____

State:_____ Zip:_____Country:_____

GUARANTOR (if Minor)

Subscriber if Insured: _____

Social Security No.: _____

Date of Birth (mm/dd/yyyy): _____

PHARMACY

Preferred Pharmacy:_____

RX History Consent: _____Yes _____No

X_____Date _____

Signature

All Refills must be requested through your pharmacy or via the patient portal.

ACKNOWLEDGEMENT OF RECEIPT

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received/read a copy of this medical practice's Notice of Privacy Practices.

Signed: X _____

Print Name:_____

Phone:_____

Name of Patient: _____

Relationship to Patient:_____

Date: _____

FINANCIAL POLICY/ AGREEMENT

Thank you, for choosing us as your health care provider. The following is a statement of our Financial Policy, which we require you to read, and sign, prior to any treatment.

- **PAYMENT OF DEDUCTIBLE, CO-PAYMENTS, AND ANY UNCOVERED SERVICES ARE DUE AT TIME OF SERVICE.**
- **ON MINOR CHILDREN, WHICHEVER PARENT BRINGS THAT CHILD IN FOR SERVICES WILL BE RESPONSIBLE FOR THE BILL/CO-PAY.**
- **NON-INSURED PATIENTS ARE EXPECTED TO PAY IN FULL AT TIME OF SERVICES.**
- **WE ACCEPT CASH, CHECK, OR CREDIT CARDS.**

It is your responsibility to provide the receptionist with your most current vital information. You will need to provide a copy of your insurance card upon each visit, and notify us immediately if any of the information changes.

INSURANCE POLICY:

Your insurance coverage is a contract between you and your insurance company. As a courtesy to you we are happy to file your insurance for you. However, you are responsible for paying all co-payments, deductibles, and non -covered services. We are not a party to the contract between the patient and their insurance company. We have our own contractual obligations with each of our participating insurance companies.

In the event of assignment of benefits, you are still ultimately responsible for all charges. If your insurance company has not paid your account in full within 45 days you will be responsible for paying the balance.

MEDICARE POLICY:

We accept Medicare Assignment on all Medicare claims. This means that we will reduce our fee to the amount allowed by Medicare. We will file one (1) secondary claim for you. You must provide us with the current and correct information at the time of your visit. If you have more than one (1) secondary insurance, you will have to file it yourself. If you ask us to perform a procedure that we believe Medicare will not approve, you will be required to sign an ABN (Advance Beneficiary Notice). Medicare requires this form be signed prior to you receiving the service. You will be required to pay the cost of the non-covered service at the time of the visit.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. We are committed to your treatment being successful.

ASSIGNMENT OF BENEFITS:

I assign directly to Dr. Randy D. Walker all insurance benefits, if any, payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are paid by my insurance carrier. I authorize the use of my signature on all insurance submissions. Dr. Walker may use my health care information and may disclose such information to my health care insurance and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

COLLECTIONS POLICY:

In the event of nonpayment on your account our office reserves the right to turn your account over to a collection agency/attorney in order to obtain payment.

I have read, understand, agree to the Financial Policy guidelines.

Patient
Signature: x_____