EmergiCare of Harrisonburg
Registration Form

Section 1. **Patient Information**

Name: _____Suffix:_____
Gender: _____Date of Birth: _____/_____/_____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Phone: (_____) _____ Cell Phone: (_____) _____
Email Address: _____
Employer/School: _____ Work Phone: (____) _____
Emergency Contact: _____ Phone: (_____) _____
How did you hear about us? _____
Check Appropriate Box: ☐ Minor ☐Single ☐Married ☐Widowed ☐Divorced

Section 2. **Parent/Guardian Information (IF UNDER 18)**

Relationship to Patient: ☐Parent ☐ Other
Name: _____
Address: _____
City:_____
Phone:(_____) _____ Email:_____ Date of Birth: _____/_____/_____
Employer:_____ Work Phone: (____)_____

Section 3. **Billing Information**

Most services rendered during your visit will be submitted to your insurance company, employer or third party payer. There is no guarantee of payment until they receive and process the claim. Any copay, coinsurance or deductible that is over charged shall be reimbursed to the patient within 60 days from the time your insurance carrier notifies us. Any amount that was not collected at the time of service, that your insurance carrier deems your responsibility, will be sent to you as a bill. Any account balance not paid within 90 days will be referred to our collection agency.

Section 4. May we leave a message if you are not home? ☐ Yes ☐ No

May we discuss your health and billing information with a family member, spouse or other person involved in your care or payment for your treatment or services rendered (other than third-party payer)? ☐ Yes ☐ No
If yes, please name the individual(s)

_____

_____

I have read the information on this form. I have had the opportunity to ask questions and have them answered to my satisfaction. I understand and agree to all terms above unless otherwise noted. I certify that I am the **patient** or **patient's legal representative** with authority to sign this document on the patient's behalf.

_____ _____

Please Circle One: Signature of Patient /Legal Guardian / Agent under Durable Power of Attorney for Healthcare

Date

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