Dr. Gerald Miller
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Beaverton OR 97006
Phone: 503-466-1823
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Office Hours M-Th 8am-5pm

Patient Registration Form

Date: **2007**	**Referred by:**

PATIENT

Please Print

Last Name:	First:	MI:	Birth date:	Sex: M F
Address:	City:	State:	Zip:	
Home Phone:	Social Security Number: - -	Relationship to Insurance Policy Holder: ☐ Self ☐ Spouse ☐Child ☐Other	Marital Status: ☐ M ☐S ☐W	
Employer:	Work Phone: (If we may contact you there) OR Cell#:			
Email address:				

RESPONSIBLE PARTY (Insurance Policy holder or Parent, *if different from above*)

Last Name:	First:	MI:	Home Phone:
Address:	City:	State:	Zip:
Employer:	Work Phone:		

PRIMARY INSURANCE INFORMATION ☐ W.C. ☐ M.V.A

Insurance Company Name:			
Address:	City:	State:	Zip:
Group Number:	I.D. Number:	Name of Insured Policy Holder:	
Insurance Phone Number:			

EMERGENCY CONTACT

Name:		Phone Number:

Please do not sign until you have read and understand this agreement:

To help us contain the cost of medical care for you and your family, we ask for non-insured patient's payment at time of service. For insured patients, payment as required by your insurance company is due at the beginning of your appointment, when you check in at the front desk. You will be charged a **$15.00** billing fee for co-payments not made at time of service**.** We will be happy to bill your primary insurance for amounts over and above your co-pay amount, as a courtesy to you. **You must provide us with accurate and timely information regarding the details of your policy.** We are unable to bill secondary insurance at this time, but will be happy to provide you with the necessary forms for you to submit to you insurance company for reimbursement. ***It is <u>your responsibility</u> to know if you have a co-pay or deductible*** **and to make those payments at the time of service**. An account 60 day's past due becomes patients responsibility. Accounts over 90 days past due are subject to a collection fee of **$25.00** per month, unless a budget payment plan has been established and adhered to. If you need to make a budget payment agreement, please contact the office manager.

Attention Medicare beneficiaries: In most cases Medicare will bill your secondary insurance for you, Please call Medicare and make sure they have your secondary insurance information.

Please call 24 hours in advance to cancel an appointment. Those who do not cancel their appointment within the time limit will be subject to a **$25.00 NO SHOW fee** for each 15 minute interval of scheduled appointment time. **Those who show up for a scheduled appointment LATE by 15 minutes (or more) will be rescheduled**. If the patient must be fit in to the schedule due to late arrival time, a fee of **$15.00** may apply, in addition to the regular charges, and they will be seen as a "fit in".

I have read and understand this financial agreement.

_____ _____ _____

Print Name **Signature** **Date**