TEPEYAC FAMILY CENTER, LLC. dba, TEPEYAC OB/GYN

New Patient
Existing/Update

PATIENT REGISTRATION

Co-Pay

Patient Information

PLEASE PRINT –FILL ALL AREAS

First Name	M.I.	Last Name	Date of Birth	Social Security Number

Home Phone Number	Cell Phone Number	Work Phone Number	Email address
( )	( )	( )	

Home Address	City	State	Zip

Marital Status: Married Single Divorced Widowed
Spouse Name:

Employer

Race: Caucasian (White) Black/African American Asian Native American
Asian Pacific American Pacific Islander Subcontinent Asian American
American Indian or Alaskan Native Native Hawaiian Other Race
More than one race Decline to answer

Primary Care Physician's Name:
Phone Number: ( )

Ethnicity: Latino/Hispanic Other ethnicity Decline to answer

Complete If Under 18 Years or a Student

Father's First Name	M.I.	Last Name	Date of Birth	Father / Step-Father

Father's Home Address	City	State	Zip

Father's Social Security Number	Home Phone Number	Work Phone Number	Cell Phone Number
	( )	( )	( )

Mother's First Name	M.I.	Last Name	Date of Birth	Mother / Step-Mother

Mother's Home Address	City	State	Zip

Mother's Social Security Number	Home Phone Number	Work Phone Number	Cell Phone Number
	( )	( )	( )

Primary Insurance Policy Holder: Patient Spouse Parent Other *(Complete this Section)*

Subscriber/Policy Holder's Name	Relationship to Subscriber/Policy Holder		Social Security Number of Subscriber/Policy Holder	
Policy Holder's Address (if different from patient)	**Sex of Policy Holder** Male Female	**Co-Pay**	**Birthdate of Policy Holder**	**Effective Date**
Primary Insurance Company Name and Address	**Identification/Policy Number**		**Group Number**	
City	**State**	**Zip**	**Policy Holder's Phone Number**	
			( )	

Secondary Insurance Policy Holder: Patient Spouse Parent Other *(Complete this Section)*

Subscriber/Policy Holder's Name	Relationship to Subscriber/Policy Holder		Social Security Number of Subscriber/Policy Holder	
Policy Holder's Address	**Sex of Policy Holder** Male Female	**Co-Pay**	**Birthdate of Policy Holder**	**Effective Date**
Secondary Insurance Company	**Identification/Policy Number**		**Group Number**	
Secondary Insurance Company Address	**State**	**Zip**	**Policy Holder's Phone Number**	
			( )	

Emergency Contacts

Emergency Contact Name	Relationship to Patient	Phone Number
		( )
Emergency Contact Name	**Relationship to Patient**	**Phone Number**
		( )

I certify that the information I have reported above is correct and that as the Patient/Parent/Guardian/Guarantor I have read, understand and fully accept the Conditions of Registration as stated <u>on the back</u> of this document.

Signature _____ Print Name _____ Date _____

Read and Initial Conditions of Registration on the Back of this Form

CONDITIONS OF REGISTRATION

THE PRACTICE
Tepeyac Family Center LLC, dba, Tepeyac OB/GYN and/or its physicians, employees, agents or assignees will hereafter be referred to as "The Practice".

CONSENT FOR TREATMENT
The undersigned hereby consents to the administration of such medical treatment, diagnostic and/or therapeutic procedures and surgery as required by the physician rendering care for themselves and/or their child(ren). The procedures may include, but are not limited to, surgery, laboratory and x-ray procedures.

AUTHORIZATION & ASSIGMENT OF INSURANCE BENEFITS
I do hereby authorize The Practice to apply for benefits for services rendered to myself or minor child(ren) under Medicaid, Medicare, or any health insurance policies/programs providing benefits and do hereby also assign and authorize payment of benefits from my (our) insurance company to The Practice (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency.) I irrevocably authorize all such payments to The Practice. I authorize The Practice to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my (our) benefits.

RELEASE OF MEDICAL INFORMATION
I authorize The Practice to release any and all of my or my minor child(ren)'s medical records and/or other information and records required by my (our) insurance company or its designated review agents who provide insurance benefits on my (our) behalf, including if applicable, my employer and/or employer's workman's compensation insurance company, the Social Security Administration, or the Centers for Medicare & Medicaid Services CMS, needed to determine benefits and to process insurance claims and secure payment of benefits to either the insured or to The Practice; and authorize any hospital, lab, physician, or other healthcare provider and/or their staffs and to release my or my minor child(ren)'s medical records and/or other records and information on myself or my minor child(ren) to The Practice as required for payment of benefits and/or required for medical or any other reasons; and authorize The Practice to release the above mentioned records for any of the above reasons. I agree to pay any applicable charges for having records copied. Such charges not to exceed .61 per page in addition to regular postage and a $18.54 handling fee.

REFERRALS AND AUTHORIZATIONS
If I have an insurance plan that requires any referrals, pre-certifications or authorizations I understand that it is my responsibility and not The Practice's to obtain approval from my insurance plan for medical services and/or procedures prior to such medical services and/or procedures being rendered. Some insurance companies may take up to 48 hours or more to obtain a referral. Additionally, if any aforementioned procedures are not done and medical services and/or procedures are rendered without the proper insurance approval, I understand that this may cause reduced or rejected coverage for which I will be held responsible and that any of these aforementioned actions do not guarantee that my insurance company will pay for the claims. Any denial of claims is between the policyholder/subscriber and their insurance. I (we) agree to inform The Practice immediately of any change in insurance coverage and/or benefits and change of personal information. I understand medical services may not be rendered without the proper referral on file.

FINANCIAL AGREEMENT
I agree that payment in full is due at the time of treatment. I also understand that I (we) may be billed separately for services rendered by other professionals including, but not limited to other physicians, radiologists, and laboratory work, as appropriate and in accordance with the services rendered. The Practice will file for insurance benefits and accept payments per The Practice's contractual agreements with the insurance company. Any questions or disputes concerning insurance coverage or payment of benefits is a matter between the insurance subscriber/policyholder and the insurance company. Any assistance in this matter granted by The Practice is given strictly as a courtesy and implies no responsibility on The Practice's part for filing, follow through or confirmation. I agree to pay the Walk-in fee of $50.00 in addition to the office visit if I arrive without an appointment and without practice foreknowledge. I agree to pay a $50.00 fee for missed appointments that are not cancelled at least 24 hours in advance. I agree to pay a $30 fee for replacement prescription, orders, forms, or other documents previously provided by the office. I agree to pay $25 for any reason a check is returned on my account I will be responsible for a $25.00 returned check fee in addition to the original fees for services. Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, not adding a dependent to insurance plan, non-payment at time of service and/or any other reason I agree to pay all charges within 30 days of services rendered. Interest of one and one-half percent per month, eighteen percent per annum, will be charged on all accounts over 30 days. If the balance is not paid within the 30 days or if agreed upon payment arrangements on my (our) account are not made, I authorize the practice to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and to notify the credit bureaus of my (our) delinquencies. I understand that this will affect my (our) credit rating. If this account is placed for collection, I agree to pay one-third of the unpaid principal and interest as a collection or attorney fee, plus court costs and interest in the amount of one and one-half percent per month, beginning 30 days after the monies have become due or expenses have been incurred. Any expenses incurred by such collection actions, including maximum allowed interest, shall become an additional liability for which I (we) assume full responsibility. I understand and agree that the terms herein are reaffirmed each time services are received.

COPY OF SIGNATURE
I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic or telephonic.

CERTIFICATION
I certify that the information I have reported with regard to my (our) insurance coverage is correct and that the above be honored by my (our) insurance carriers. This certification will also apply to application for benefits under Title XVIII of the Social Security Act and/or any other governmental agency, if applicable. I also certify that I have read the forgoing and understand and fully accept the terms therein.

I have read, understand and fully accept the Conditions of Registration.

_____ _____
Initials Date