MORGAN KALMAN CLINIC

STOP SPORTS INJURIES
PARTICIPATING SPORTS MEDICINE PRACTICE

PATIENT REGISTRATION FORM

IF YOU REQUIRE ASSISTANCE FILLING OUT THIS FORM NOTIFY THE RECEPTIONIST

PERSONAL INFORMATION TODAY'S DATE _____ SSN: _____

FIRST NAME _____ MI _____ LAST NAME _____

Address_____

Date of Birth_____ Age _____ Marital Status _____ Sex M F

Contact Information Home _____ Cell _____ Work _____

Employer Name_____

Full Time Student ❑ Yes ❑ No Where _____

Primary Care Physician _____ Phone # _____

Who referred you?_____ (MD- DO- PA- NP) Phone#_____

IN THE EVENT OF AN EMERGENCY I GIVE PERMISSION TO CONTACT:

Name _____ Relationship _____ Phone# _____

MINOR PATIENTS

Name of Parent/Guardian _____ Phone # _____

INSURANCE INFORMATION

Primary Insurance _____ Insured's Name _____

Patient's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other

Policy # _____ Group _____ Specialist Copay _____

Address of Policy Holder_____ Employer Name _____

SSN of Policy Holder _____Date of Birth _____

Secondary Insurance _____ Insured's Name_____

Address of Policy Holder_____ Employer Name _____

SSN of Policy Holder _____Date of Birth _____

Patient's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other

Other Policy# _____ Group _____ Specialist Copay _____

Address of Policy Holder_____ Employer Name _____

SSN of Policy Holder _____Date of Birth _____

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:

If we are filing insurance for your visit, we must have complete information and any required referral at the time of your visit.
If you cannot provide the information, we will be unable to file your insurance. Payment in full will be required at the completion of your visit.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan. The amount applied to your plan deductible or co-insurance will be your responsibility. Procedures which are excluded from coverage, based on your plans determination of medical necessity will also be your responsibility. Your office visit copay is due at the time of the visit and often covers only the office visit charge. Any procedures performed will be considered surgery by your insurance carrier and deductibles and coinsurance may apply.

For all other patients, ***payment is required at the time of service.*** The office staff can provide you with the necessary documentation to file for reimbursement upon your request.

I have read the above information and understand that I am responsible for payment for services I receive.

Signature of person who has read and completed form

_____ Date _____