

Robert Fitton, MD/ Brookfield Primary Care, LLC REGISTRATION FORM

(Please Print)

| Today's Date: | | | | PCP: | | | | | | |
|--|---------------------------------|---|---------------------------------------|--|---|---|------------------------------|-----------------------------------|---|------------------------------|
| PATIENT INFORMATION | | | | | | | | | | |
| Patient's last name: | | First: | Middle: | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. | <input type="checkbox"/> Miss <input type="checkbox"/> Ms. | Marital status: | | | | |
| | | | | | | Single <input type="checkbox"/> | Mar <input type="checkbox"/> | Div <input type="checkbox"/> | Sep <input type="checkbox"/> | Wid <input type="checkbox"/> |
| Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Home phone #: () | | Cell phone #: Preferred ? <input type="checkbox"/> Yes () | | Birth date: | | Age: | Sex: <input type="checkbox"/> M <input type="checkbox"/> F | |
| Street address: | | | | Social Security no. (optional): | | | | | | |
| P.O. box: | | City: | | | State: | | ZIP Code: | | | |
| Occupation: | | Employer: | | | | Employer phone no.: () | | | | |
| Chose clinic because/referred to clinic by (Please check one box): | | | | <input type="checkbox"/> Dr. | | <input type="checkbox"/> Insurance plan | | <input type="checkbox"/> Hospital | | |
| <input type="checkbox"/> Family | <input type="checkbox"/> Friend | <input type="checkbox"/> Close to home/work | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Other | | | | | | |
| Other family members seen here: | | | | | | | | | | |

| INSURANCE INFORMATION | | | | | | | | | | | |
|--|--|-------------------------------|---------------------------------|--------------------------------|--------------------------------|-------------------------------|--|-------------|--|-------------------|--|
| (Please give your insurance card to the receptionist.) | | | | | | | | | | | |
| Person responsible for bill: | | Birth date: | | Address (if different): | | Home phone no.: () | | | | | |
| Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | |
| Occupation: | | Employer: | | Employer address: | | Employer phone no.: () | | | | | |
| Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | |
| Name of primary insurance | | | | | | | | | | | |
| Subscriber's name: | | | | Birth date: | | Group no.: | | Policy no.: | | Co-payment: \$ | |
| Patient's relationship to subscriber: | | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child | <input type="checkbox"/> Other | | | | | | |
| Name of secondary insurance (if applicable): | | | Subscriber's name: | | | Group no.: | | Policy no.: | | | |
| Patient's relationship to subscriber: | | <input type="checkbox"/> Self | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child | <input type="checkbox"/> Other | | | | | | |

| IN CASE OF EMERGENCY | | | | | | | |
|---|--|--------------------------|--|---------------------------|--|---------------------------|--|
| Name of local friend or relative (not living at same address): | | Relationship to patient: | | Home phone no.: () | | Work phone no.: () | |
| <p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.</p> | | | | | | | |
| <hr/> <i>Patient/Guardian signature</i> | | | | | | <hr/> <i>Date</i> | |

Office Policies

Please read the following carefully and sign below when complete. If you do not understand a particular policy, please ask our staff for clarification.

Assignment/Financial. Balances and Co-payments:

- ❖ I authorize my insurance company to pay medical benefits directly to my physician for services provided in the office.
- ❖ I understand that I am responsible for any co-payments, deductibles, non-covered services and/or unpaid balance. This applies to all insurance programs including MEDICARE.
- ❖ All balances should be paid within 30 days. Accounts with balances greater than 30 days are subject to interest allowed by law.
- ❖ For accounts with balances over 90 days, patients will be discharged from the practice and the account will be turned over to a collection agency.
- ❖ Co-payments are payable at the time of visit, unless arrangements are made in advance.
- ❖ Any "billed" co-payments, will be assessed a \$10 surcharge.

Referrals

- ❖ If your insurance policy requires "referrals" (prior authorization to see a specialist or get tests):
- ❖ The physician has the right to evaluate the patient before a referral is authorized and the referral process takes 2 to 3 working days.
- ❖ Referral authorization **cannot** be backdated, it is the responsibility of the patient to ensure referrals are in place at the time of referred visits or services are rendered.

Prescription Refills

- ❖ Prescription refill request take 24-48 hours to process and are refilled during office hours only.
- ❖ Many medications require monitoring of the patient and/or their laboratory functions. The follow-up interval and the length of prescription will be determined by the physician.

Form Completion Fees

- ❖ There is a \$25 fee (not covered by insurance) for completion for forms up to 4 pages and forms will be completed in 5 business days. This does not include sports, school or camp physicals as long as the patient has been seen by the Doctor within one year. Please contact the office for pricing information for longer forms and letters.

No Show Policy

- ❖ Please notify the office within 24 hours of your appointment if you are not able to make an appointment. Missed (no-show) appointments are subject to a \$40 fee per missed appointment (not covered by insurance). Patients with more than 3 "no shows" will be discharged from the practice.

HIPAA RECEIPT OF INFORMATION

- ❖ I acknowledge I have received a copy of the Notice of Privacy Practices and that I can address questions, complaints and concerns to the practice administrator.
- ❖ I, the undersigned patient, hereby authorize Brookfield Primary Care, LLC and Robert Fitton, MD to use my medical information ("Individually Identifiable Health information) for treatment, payment and health care operations purposes.
- ❖ I have read, understand and agree to comply with all of the above policies.

Patient or Guardian Signature Date

Visit our Web site at www.drfitton.com. You can request appointments and renew prescriptions. Try it, it is informative and easy.

Effective Date: 1/1/2011