Laura Norton Petrovich, MD PC

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single/ Partner / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Best Contact :( ) Cell phone: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer or School:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other	Primary Language spoken:

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? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]

❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ Welfare *(Please provide coupon)*	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ 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.: ( )

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 Laura Norton Petrovich, MD PC or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Acknowledgement of Receipt of Notice of Privacy Practices and Patient Consent

My practice reserves the right to modify the privacy practices and consent form outlined in the notice.

Signature:
I have been offered access to a copy of the Notice of Privacy Practices and Patient Consent Form for the medical practice of Laura Norton Petrovich, MD PC.

_____
Name of Patient (print)

_____
Signature of Patient or representative

_____
Date

_____
Relationship of Patient Representative to Patient

Laura Norton Petrovich, MD PC
1224 10th Street, Suite 200
Coronado, CA 92118

Dear Patient:

Our office knows that insurance plans can be complicated, and we make every effort to answer your questions. It is up to you to know the requirements of your health plan prior to your visit. Please let us know if your plan requires you to use a contracted lab, radiology group or a certain group of specialists, doctors or hospitals. In addition, if you health plan requires a referral to see someone other than your primary care physician, be sure that the referral is approved before seeking care. Again, it is your responsibility to know the procedures and protocols of your health plan.

If your insurance requires a co pay, please be prepared to pay at the time of your visit. Please bring your HMO or PPO/POS card to each visit in case we need to verify any insurance matters. If there is no eligibility for the date of the visit, be prepared to pay for the services at the time of the visit. Please be aware that some health plans do not cover well visits and vaccines, and you will be responsible for the balance due if this is the case.

Please do not assume that we know the details of your health plan. We deal with over 100 different plans, and each plan has different requirements and benefits.

We ask that you read your health plan booklet carefully and understand your coverage.

Thank you,

Laura Norton Petrovich, MD and staff

_____ _____

Signature of Patient/Parent/Guardian Date

Laura Norton Petrovich, MD PC
1224 10th Street, Suite 200
Coronado, CA 92118

No Show Policy

If a patient does not show for a scheduled appointment and does not cancel within 24 hours of the scheduled time, a **$50 "no-show"** fee will be assessed to the responsible party.

We have decided to implement this policy as some patients have consistently not shown for their appointments and given no prior notification, leaving us with fewer time slots for same day appointments for other patients. We will fulfill our part by giving you a call the day before your appointment (on Friday if you have a Monday appointment scheduled.)

Our goal is not to penalize those who do not show for a scheduled appointment, but instead to free up the time to see those patients that need to be seen on a same day basis. We really just want a courtesy call.

Thank you for making our office more easily accessible to our patients.

I acknowledge receipt of the no-show policy by signing below.

_____

(Signature)