EAST TEXAS PRIMARY CARE

Patient Registration

PATIENT INFORMATION

Last Name:	First Name:	M.I.:
Address:		Apt#
City/State/Zip:		
Date of Birth: / /	SSN: - -	Gender: ☐Male ☐Female
Home Phone:	Cell Phone:	Work Phone:
Call Preference: ☐Home ☐Cell ☐Work	Email Address:	
Emergency Contact Name/Relationship:		Emergency Contact Phone:
Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Partnered		

ADDITIONAL INFORMATION AND RESPONSIBLE PARTY

Responsible Party – If the patient is a minor (under the age of 18), the parent or guardian will be listed as the guarantor:

Last Name:	First Name:	
Date of Birth: / /	SSN: - -	Phone:
Address of Person Responsible:		
City/State/Zip:		Relationship to Patient:

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):

Race: ☐African American ☐Caucasian ☐Native American ☐Asian ☐Other:	
Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino	Preferred Language:
Preferred Pharmacy Name:	Pharmacy Phone:

INSURANCE INFORMATION

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name	Ins. Co. Name
Policy ID/Group:	Policy ID/Group:
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's SSN:	Policy Holder's SSN:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I certify that I have read and agree to East Texas Primary Care's (ETPC) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I authorize ETPC to release any medical information to my insurance carrier or third-party payer to facilitate processing my insurance claims as well as outside providers for the coordination and collaboration of care. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $20.00 returned check fee will be charged for checks returned due to insufficient funds.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to ETPC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of East Texas Primary Care's Privacy Notice.

Signature of Responsible Party: _____ Date: _____

Printed Name of Responsible Party: _____ Date: _____

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EAST TEXAS PRIMARY CARE

Payment Policy

As a medical practice, our goal at East Texas Primary Care is to provide you with the best possible medical care. As a small business, we strive to be patient, friendly, and cost effective. This payment policy represents our effort in this area. If you have any questions, please feel free to contact us.

Payment is expected at the time of service for all cash pay visits. Payment plans are considered on a case-by-case basis.

If you have insurance, we will happily bill it for you. All insurance information must be provided and verified prior to each visit. Determining the cost of a visit when you use insurance is quite difficult as each policy can have a different co-payment, co-insurance or deductible, and our contracted rates vary with every insurance contract. Co-payments and co-insurance are due at the time of service, but frequently we must bill the insurance and await a statement from them called an explanation of benefits (EOB) to determine the remainder of what you might owe. Once we receive the EOB from your insurance, any remaining payment is due within 30 days of receiving your mailed invoice.

Although we are contracted with most insurance carriers, our services may not be covered by your insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100% responsible for all charges incurred.

Payment options include mailing cash, local checks, or credit card information with the returnable slip received with your mailed invoice. All returned checks will incur an additional fee of $20.00. Payment may also be rendered via credit card on our website or over the phone through our office number. Regardless of the form of payment, all patients will receive a mailed receipt of your payment. Any credits will be refunded promptly.

You retain the right to contest EOB determinations with your insurance company. We diligently assist patients with this, often appealing even before billing the first time.

We take safeguarding your financial information as seriously as we take protecting your personal health information.

If you do not have a credit card or otherwise object to the policy above, please review this with one of our providers to create an individual plan.