Jorge Campaña, MD, PC

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: ____

SSN: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female

Street Address: _____

City: _____ State: _____ Zip: _____

(Fed Govt. Requirement) Race: ☐ American Indian/Native Alaskan ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other

(Fed Govt. Requirement) Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ ext_____

Cell Phone: (_____) _____-_____ Email Address: _____ @ _____. ____

PRIMARY INSURANCE INFORMATION (Must present insurance card to our staff)

Ins Co: _____ Policy #: _____ Group #: _____

Patient's relationship to the Subscriber (if other than self include info below): ☐ Self ☐ Spouse ☐ Child

Last Name: _____ First Name: _____ MI: ____

SSN: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

SECONDARY INSURANCE INFORMATION (Must present insurance card to our staff)

Ins Co: _____ Policy #: _____ Group #: _____

Patient's relationship to the Subscriber (if other than self include info below): ☐ Self ☐ Spouse ☐ Child

Last Name: _____ First Name: _____ MI: ____

SSN: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female

Street Address: _____

City: _____ State: _____ Zip: _____

TERTIARY INSURANCE INFORMATION (Must present insurance card to our staff)

Ins Co: _____ Policy #: _____ Group #: _____

HIPAA Release of Private Health Information

I hereby authorize the release of any private health information (PHI) obtained in the course of my registration, interview, examination and treatment, necessary to file or appeal any claim with my insurance carrier(s) or deemed necessary pursuant to State or Federal law, statute or regulation. I acknowledge that if I wish to have any individual or entity restricted from access to my PHI, I will notify the office in writing. (*Please ask front desk for Restricting PHI Access form*).

Assignment of Insurance Benefits & Agreement to Pay Balance Due

I hereby authorize my insurance carrier(s) to directly pay Jorge Campaña, MD, PC any medical/surgical benefits otherwise payable to me by my insurance carrier for services as rendered.

I also accept responsibility for paying any monies not paid by my insurance carrier for a balance due to Jorge Campaña, MD, PC (including co-pays, deductibles, co-insurances and other carrier non-covered services), as well as pay for any balance which the carrier fails to consider, except that dollar amount which is limited by participating provider agreement between Jorge Campaña, MD, PC and my insurance carrier(s).

Participation, Pre-Authorizations, Referrals

I understand that I am responsible for contacting my insurance carrier(s) to confirm if Jorge Campaña, MD, PC is participating with my insurance carrier(s) and that I am eligible for benefits on or before the date my visit(s) take place. I also agree to pay and not bill my insurance carrier(s) for any claim that is past timely filing due to the fact that I did not present my correct insurance card(s) to Jorge Campaña, MD, PC before the timely filing deadline lapsed.

Furthermore, I agree to contact my insurance carrier(s) and/or Primary Care Physician to determine if it is necessary to obtain any pre-authorizations/referrals before my visit(s) take place. Moreover, I agree to pay for any dollar amount denied or applied to my deductible by my insurance carrier(s), due to the fact that I failed to present a pre-authorization/referral at the time of my visit.

Missed Appointments and Collections

I recognize that Jorge Campaña, MD, PC reserve the right to charge me for missed appointments and appointments cancelled with less than 24hrs notice.

If at any time I have a balance due which is more than 90 days old I understand that my account may be referred to an outside collection agency without notice. If my account is sent to a collection agency, I hereby agree to pay for all collection costs incurred while collecting my debt in addition to finance charges at the rate of 1.5% per month.

A copy of my signature consenting to this agreement is as valid as the original, and shall continue to be valid for one year from the date of signature.

_____ _____/_____/_____

Patient/Responsible Party Signature Date of Signature