DATE _____ PATIENT # GUARANTOR #

PATIENT INFORMATION

Name _____ Date of Birth _____ Sex _____

Social Security # _____ Primary Phone _____ Second Phone _____

Mailing Address _____ Unit/Apt # _____ City _____

State _____ Zip _____ Email Address _____

Employer _____ Work Phone _____

Race (select one or more):
___American Indian/AK-Native
___Asian
___White
___Black/African American
___Native Hawaiian/Other Pacific Islander
___Patient Declined
___Unknown (Unable to provide)

Ethnicity (select only 1):
___Hispanic or Latino
___Not-Hispanic or Latino
___Patient Declined
___Unknown (Unable to provide)

Primary Language:
___English
___Spanish
___French
___German
___ Unknown (Unable to provide)

PCP _____

PARENT/ GUARDIAN IF PATIENT IS CHILD/SPOUSE

Name - Last _____ First _____ Middle _____

Relationship _____ Social Security # _____

Date of Birth _____ Mailing Address _____ Unit/Apt # _____

City _____ State _____ Zip _____ Home Phone _____

Email Address _____ Cell Phone _____

Employer _____ Work Phone _____

EMERGENCY CONTACT *OR* 2nd Parent

Name _____ Phone _____

Address _____ Relationship _____

Insurance billing information for contracted carriers will be taken directly from your insurance card. Please present your card to the desk personnel once you have completed this form.

Bus.01 01/16

! PLEASE SIGN AND DATE REVERSE !

FOR OFFICE USE ONLY
Receptionist initials/Date: Front Desk Initials/Date: Entered / Appt Date / Dr

BOULDER MEDICAL CENTER PAYMENT POLICY for New and Established Patients

CHARGES AND PAYMENTS: We ask all of our patients to pay for their care at the time services are rendered, or to provide us with a current copy of their insurance card. Payment may be made with cash, check, money order or credit card. For your convenience, we accept Visa, MasterCard, American Express and Discover.

If you belong to a health insurance plan that our office does bill directly, you may be expected to pay all deductibles, co-insurance or co-payments, and any non-covered benefits at the time services are rendered. Co-pays must be made at the time of service in order to be seen. Every plan is different, so please contact your insurance company or HR department for specifics on your plan.

If you have insurance that BMC is not participating with, it is your responsibility to pay for the charges at the time of service and to file the proper claim forms and to collect a reimbursement payment directly from your insurance company. Insurance claim forms can be mailed to you if you request them from our Business Office.

You are responsible for informing us of all your insurance coverage(s). All disputed or pended claims will immediately become your financial responsibility.

A copy of your charges may be provided to you by your doctor at the time of service. Please request them before you leave the area. We realize that illness and injury can sometimes cause unforeseen hardship on you and your family. If your charges at the time of service exceed $185.00, we only require payment of $185.00 on the date of service. The remaining balance on your account is due upon receipt of the statement.

Laboratory and/or radiology tests and services are ordered by your practitioner before, during or after your visit. Some services may not be covered by your insurance, or they may go towards your deductible. Coding for these services will be determined by your practitioner and will not be changed to satisfy any insurance benefit limitation. **Please note that any laboratory or radiology services that are ordered by your physician are administered by outside facilities.** You may receive a statement from a lab or radiology department outside of Boulder Medical Center. Please pay that facility directly and not Boulder Medical Center for those services.

STATEMENTS and COLLECTIONS: An itemized statement will be mailed to you monthly if there is an outstanding balance due from you. The balance on your account is due upon receipt of the statement. There may be a monthly re-billing fee added for past due statements. If you remit payment by a check which is later dishonored by your bank for any reason, a $20.00 returned check charge will be added to your account. We may not inspect or look for special instructions or "restrictive endorsements" on every check. For this reason, we are not able to honor any special instructions or be bound by a restrictive endorsement placed on checks. In addition, we will not accept signed over or third party checks as payment on an account.

A $75.00 fee may be assessed for a late cancellation or no show appointment. Cancellations and changes need to be made at least 24 hours in advance of the scheduled appointment time.

In the event that your account is assigned to a collection agency for enforcement of this agreement you are responsible for all fees. If your account is still not resolved, the case may be referred to an attorney, who is not a salaried employee of Boulder Medical Center and you will be liable for any reasonable attorney's fees. In the event that your account is assigned to a collection agency multiple times, all members of your account may be in jeopardy of losing the right to receive future services at BMC. Bankruptcy may also jeopardize the right to future service. While your account is in collections Boulder Medical Center may ask you to pay for services received on the same date you are seen; account billing may resume once your account is back in good standing.

In the event of divorce, separation or custodial cases, the guardian or parent bringing the dependent to the office will be held financially responsible. No one will be added to or deleted from an account unless agreed upon by all parties. When a child reaches 18 years of age our office may put the child on his or her own account.

By signing this registration form, you are giving permission to Boulder Medical Center and its successors to call you on any cell phone that you provide that is owned or utilized by you.

I have read, understand, and agree to the Boulder Medical Center Payment Policy for New and Established Patients

_____ _____

Date Signature

_____ _____

Date Person authorized to sign for patient (if under age 18)

RELEASE OF RECORDS: I authorize the release of any medical, psychiatric, drug or alcohol information necessary to process Boulder Medical Center insurance claims. I understand that copies of my medical records may be sent to process insurance claims.

_____ _____

Date Signature

_____ _____

Date Person authorized to sign for patient (if under age 18)