BROWNSTONE
TOTAL FAMILY HEALTHCARE

PATIENT REGISTRATION

PATIENT INFORMATION

Last Name:	First Name:	M.I:	Date of Birth:
Sex: ❑ M ❑ F	Race: ❑Declined	Ethnicity: ❑Declined	Preferred Language: ❑Declined
Home Address:			Apartment #:
City:	State:	Zip Code:	Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced
Home Phone: ❑Preferred	Cell Phone: ❑Preferred		Work Phone:
Email:		Employer:	
Pharmacy Name:	Pharmacy Phone Number:	Annual Gross Income: Choose one	❑ Less than $100,000 ❑ $100-150,000 ❑ $151-200,000 ❑ $201-250,000 ❑ $251-300,000 ❑ $300,000+

PRIMARY INSURANCE INFORMATION

Insurance Name:		Effective Date:
Subscriber Name:	ID #:	Group #:
Subscriber DOB:	Email:	
Relation to Patient:	Subscriber Employer:	Subscriber Work Phone:

SECONDARY INSURANCE INFORMATION

Insurance Name:		Effective Date:
Subscriber Name:	ID #:	Group #:
Subscriber DOB:	Email:	
Relation to Patient:	Subscriber Employer:	Subscriber Work Phone:

EMERGENCY CONTACT INFORMATION

Name:	Relationship to patient:	Home Phone:	Cell Phone:

I authorize my insurance benefits to be paid directly to the physician and I agree to be financially responsible for all charges incurred. I hereby consent to the release and re-disclosure of my financial records to enable or facilitate the collection, verification, or settlement of my account for any amounts due from me or any third party payer, health maintenance organization, insurer or other health benefit plan. This consent applies to Brownstone Total Family Healthcare, any of its affiliates or agents, lenders, or any third party services acting on behalf of BTFH.

I agree to pay for services rendered to me or the above named patient at the time of service or upon receipt of the first statement mailed by BTFH. I promise to pay my account when due and should this account become delinquent and collection becomes necessary, the undersigned agrees to be responsible for attorney's fees of thirty-three and one third percent (33 1/3%), interest at eighteen percent (18%) per annum from the last date of payment and any and applicable court costs. I further agree to pay for any reasonable fees for missed appointments of which I did not notify the medical office at least 24 hours prior to your appointment.

In the event that a check is returned for insufficient funds, we will notify you and give you ten days to pay the amount of the delinquent check in full plus a $35.00 returned check fee. If we do not receive the cash payment in full within ten days, we will submit this delinquent account over to our attorneys at which time any and all civil penalties as provided by the state of Alabama.

I authorize BTFH to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

I, _____ (print full name) as the financially responsible party to the above named patient agree to the aforementioned statements and authorize payment of medical benefits to Brownstone Total Family Healthcare for services rendered.

Patient/Guardian signature *Date*