REGISTRATION FORM

(Please Print)

Today's date:	Referring healthcare provider:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Married / Divorced / Minor

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

Mailing address:	Social Security # :	Best contact # : ( )

City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone # : ( )

Email Address:	Driver's License #	State Issued:

Who referred you? How did you hear about Real Time? ❑ Dr. ❑ Website ❑ Hospital ❑ Family ❑ Friend ❑ Matsu Valley relocation guide ❑ Facebook ❑Other

RESPONSIBLE PARTY

Last name: First: Middle:		
Relationship to patient: ❑ Self ❑ Spouse ❑ Child ❑ Parent of minor ❑ Other	Birthdate: / /	Gender: ❑ M ❑ F
Mailing address:	Social Security #.:	Phone # : ( )

City:	State:	ZIP Code:

INSURANCE INFORMATION

(Please give your insurance card(s), Medicaid card and ID to the receptionist.)

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. # :	Birth date: / /	Group # :	Policy # :	Co-payment: $

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

Name of secondary insurance (if applicable):	Subscriber's name:	Group # :	Policy # :
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other		DOB: / /	

MEDICAID APPLICATION STATUS PENDING APPROVAL: ☐ YES ☐ NO

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided the opportunity to review the Real Time II, LLC Notice of Privacy Practices. I certify that 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 Real Time II, LLC or insurance company to release any information required to process my claims. I agree to inform Real Time II, LLC of any changes in my insurance or in the above information. I agree to bring my Denali Care Card when received if eligibility was in pending status at the time of exam. I understand and agree that I am financially responsible for all charges that are not covered by my insurance OR if it is determined that I was not eligible on the date(s) of service rendered while my Medicaid status was pending.

_____ _____

Patient/ Guardian Signature *Date*

Patient Financial Policy

Private Insurance

We will gladly bill your primary and secondary insurance companies for you. However, payment for services is expected within 60 days from a primary insurance company and within 90 days from a secondary insurance company. It may become necessary for you to pay your account in full if your insurance companies fail to pay for services within 60 days.

Insurance co-payments are due at the time of service. You are responsible for charges not covered by your insurance company. Please verify insurance benefits prior to any procedure and provide us with your current insurance information. It is your responsibility to understand your coverage and benefits and to ensure all insurance information is current.

_____Initials

Not all services are a covered benefit in insurance contracts. Some insurance companies select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend our patients, all charges are your responsibility from the date services are rendered.

_____Initials

Medicaid

Medicaid co-payments are due at the time of service. If you have applied for Medicaid and are pending approval, you will have 45 days to provide our office with the required documentation proving eligibility. If this information is not received within 45 days, your account will be considered a self-pay account and payment on account will be required.

_____Initials

Self-Payment

Payment is due at the time of service. A 15% discount is offered if payment is made in full at the time of service. If payment cannot be made in full, a payment arrangement will be made at the time of service.

_____Initials

Outstanding Balances

Payment arrangements must be made on accounts with a balance of $150 or more. Consecutive monthly account payments are expected to avoid your account being reviewed for collections. If payment is not made for 3 consecutive months, your account will be assigned to our debt collection agency. Returned checks will result in a $25 fee posted to your account.

_____Initials

I have read and understand the above financial policy. I hereby assign all medical benefits to which I am entitled to Real Time II, LLC. A photocopy of this other authorization is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Real Time II, LLC to release information officially acquired in the course of examination that may be needed to secure payment. If the account is referred to an attorney for collections, I understand I am responsible for attorney fees and collection expenses. I understand that in connection with collection procedures that Real Time II, LLC has the right to request, receive, and renew all credit information as provided by a licensed and duly operated credit bureau.

_____ _____

Signature of patient / Guarantor Date

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Patient Name (please Print)