



Ridge Family Practice, P.C.
Patient Registration Form

Patient Information

Patient Name: _____ Birthdate: _____
Address: _____ City: _____
State: _____ Zip: _____ Sex: M F Home Phone: _____
Patient SSN: _ _ _ _ _ Marital Status: S M W D
Employer: _____ Work Telephone: _____
Cell Phone: _____ E-Mail Address: _____
Spouse: _____ Birthdate: _____
Spouse Work Phone: _____

Emergency Contact Information

Emergency Contact Name: _____
Relationship to Patient: _____
Address: _____ City: _____
State: _____ Zip: _____ Emergency Contact No: _____
Work Phone: _____ Cell Phone: _____

Financial Policy

Thank you for choosing Ridge Family Practice for your healthcare needs. Your business is important to us. Payment is expected at the time of service for all deductibles, co-payments and any patient balance due. We participate with all major insurances. As a courtesy to you we will file your insurance when you provide a copy of your insurance card.

For your convenience we accept the following forms of payment:

- Cash or check
- Credit Cards: American Express Discover MasterCard Visa
- CareCredit (Minimum \$300 balance required in order to qualify).

If you want to pay your account on a monthly basis, we offer up to 18 months interest free with payments as low as \$10 with CareCredit. You will need to complete a brief application.

Patient balances over 120 days old will be turned over to an outside collection agency. Services will not be provided to patients in collections until all past due balances are paid.

Please indicate below your plan for payment of services.

Do you have insurance coverage? ___ Yes ___ No

___ Cash ___ Check ___ Credit Card ___ CareCredit

Please list all immediate family members below. (Spouse or minor children) that are patients of Ridge Family Practice.

| Name | D.O.B. | Relationship |
|-------|--------|--------------|
| _____ | _____ | _____ |
| Name | D.O.B. | Relationship |
| _____ | _____ | _____ |
| Name | D.O.B. | Relationship |
| _____ | _____ | _____ |
| Name | D.O.B. | Relationship |
| _____ | _____ | _____ |
| Name | D.O.B. | Relationship |
| _____ | _____ | _____ |

Consent for Release of Medical Information for treatment, payment, healthcare operations and assignment of benefits.

I have been given a copy of the Ridge Family Practice Notice of Privacy which summarizes how my individual health information may be used. By signing this form I am consenting to Ridge Family Practice's use of my health information as outlined in the Notice of Privacy.

I understand that by signing this form I am financially responsible for any balance incurred as a result of services provided to me or members of my immediate family that I am responsible for.

Signature of pt./guardian/legal representative

Date