SUPPORT FOR LIFE
Adult Services at Melmed Center

REGISTRATION FORM

MUST BE COMPLETED USING A **BLACK** INK PEN

Patient's Legal Name:_____ **M/F:**_____ **Date of Birth:** _____

Marital Status:_____ **Cellular Phone/Other:**_____ **Home Phone:** _____

Address: _____
Street **City** **State** **Zip**

Employer:_____ **Work Phone:** _____

E-Mail:_____ **would you like to receive updates about future programs via E-mail? Circle Yes No**

I authorize Melmed Center to contact me by telephone with medical information pertaining to my care. If I am unavailable, this authorization gives Melmed Center permission to leave this information either on my answering machine or with a member of my household.

Authorized Individuals
The following people are authorized to discuss my personal health information and coordinate with the Melmed Center for evaluation and treatment, including follow up appointments, telephone communication, scheduling appointments and may be contacted in case of an emergency. **(Authorized caregivers are not able to request and transfer records)**

Name_____ Relationship_____ Phone Number _____

Name_____ Relationship_____ Phone Number _____

*****PLEASE READ***CANCELLED/MISSED APPOINTMENTS*****
A SCHEDULED APPOINTMENT MEANS THAT TIME IS RESERVED ONLY FOR YOU. IF AN APPOINMENT IS MISSED OR CANCELLED FOR ANY REASON, WITH LESS THAN 48 HOURS NOTICE, THE PATIENT WILL BE BILLED ACCORDING TO THE SCHEDULED FEE. THIS FEE IS NOT GENERALLY PAID BY AN INSURANCE COMPANY.
Signature:_____ **Date:** _____

PRESCRIPTION REFILL POLICY
Our office policy is that all prescription refill requests must be made 7-10 working days in advance of running out of the medication. Refills will only be approved if follow up visits have been kept every 2-3 months. **Prescriptions will be handled only during office hours. Initial**: _____

The Melmed Center has therapy/service animals in our office. **It is your responsibility** to notify our office, **prior to your appointment**, if you have fear of, or allergies to dogs. Melmed Center will not be held liable for any incidents such as licking, nibbling, or physical contact from the dog(s). By signing this document you are aware we do have service/therapy animals in our office. Please contact us if you have any further questions.

I UNDERSTAND AND AGREE TO ALL OF THE ABOVE_____ **Date** _____
Signature of Patient

Please turn the page over and complete the other side →

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FINANCIAL RESPONSIBILITY

We charge what is usual and customary for our area. Our office policy is that full private payment or insurance co-payment/co-insurance and/or deductible, as well as, account balances are due at the time of service unless prior arrangements have been made. The adult accompanying the minor patient will be required to pay in accordance with our policies. Please understand that we will only bill insurance companies that we are contracted with. Furthermore, it is your responsibility to follow up with the insurance company to insure the claim is paid within 60 days of the date of service. We must emphasize, that as health care providers, our relationship is with you, our patient, and NOT with your insurance company. You are responsible for knowing what your insurance benefits are, including what your insurance will and will not pay for; and how to access your benefits, including obtaining referrals, etc. If you are unsure, please contact your insurance carrier. This office assumes no responsibility for your lack of knowledge regarding your insurance benefits. You are responsible for any remaining unpaid charge(s) as determined by your insurance company regardless of cause. This agreement is necessary in order to accept your insurance without having to bill you upfront. An account past due 60 days or more and payment plans that are not kept current may be subject to collection and associated fees. Please note claim information processed by the insurance company is mailed to the policy holder. If you are not the policy holder for your insurance, the policy holder (parent, spouse and/or guardian) may receive information from the insurance company pertaining to dates of service and diagnosis. Melmed Center can not be held liable for information being received from the insurance company.

Please note: Insurance cannot be billed without the patient present.

By completing the information below, you assign your insurance benefits to be paid directly to Melmed Center. You also authorize Melmed Center to release any information which may be needed for processing all of claims; certification/case management/quality improvement; and/or other purposes related to the benefits of your health plan. Furthermore, understand that it is your responsibility to ensure that proper referrals or authorizations are obtained for each visit. Finally, **we require notification of insurance changes at least one week prior** to your appointment to avoid appointment delay and/or private pay expenses.

Insurance Company:_____ Phone: (___) _____ Employer:_____

Group/Policy#:_____ ID#:_____ Employee SS#: _____

Employee/Insured's name:_____ DOB:_____

Insurance Mailing Address: _____

Some medications may require Prior Authorization. Please call your insurance company and find out what provider your PHARMACY BENEFITS are covered through. Please note: This may be located on your insurance card (i.e. Medco, Prescription Solutions, Caremark, and Express Scripts), **if not, we do need this information filled out in its entirety.**

Pharmacy Benefit Provider:_____

I UNDERSTAND AND AGREE TO ALL OF THE ABOVE_____ **Date** _____

Signature of Patient/Legal Guardian