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Vail Valley Medical Center

www.vvmc.com

# REGISTRATION FORM

(Please Print)

Clinic Name:		Today's date:		Account #:		
<b>PATIENT INFORMATION</b>						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Sex: <input type="checkbox"/> F <input type="checkbox"/> M	Birth date: / /	Social Security no.:		Home Phone:	Cell phone:	
Street address:		City/State:		Zip Code:		
P.O. Box:	City:	State:	ZIP Code:			
Occupation:	Employer:			Employer phone no.: ( )		
Chose clinic because/Referred to clinic by (please check one box):			<input type="checkbox"/> Dr.	<input type="checkbox"/> Newspaper	<input type="checkbox"/> Friend	
<input type="checkbox"/> Hospital	Primary Care Physician:					

<b>INSURANCE INFORMATION</b>					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.: ( )	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:	Employer:	Employer address:		Employer phone no.: ( )	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other

<b>IN CASE OF EMERGENCY</b>			
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ( ) Work phone no.: ( )

Other Information:

**CONSENT TO MEDICAL, SURGICAL, AND/OR PSYCHIATRIC PROCEDURES:**

The undersigned consents to the procedures which may be performed during this treatment or services, and which may include but are not limited to laboratory procedures, x-ray examination, rehabilitation, medical or surgical treatment, psychiatric procedures, anesthesia or transfusion rendered to the patient under general and special instruction of the patients physician, surgeon, psychiatrist, or mid-wife assigned by the physician.

**POLICY STATEMENT ON FINANCIAL AGREEMENT:**

The undersigned agrees whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the facility in accordance with the regular rates and terms of the facility. Should the account be referred to any attorney or collection agency for collection, the undersigned shall pay all actual attorneys fees and collections expenses. It is understood that financial liability for all services deemed non-covered by insurance will be my sole financial responsibility and are to be paid at the time of services or within thirty (30) days upon receipt of my Explanation of Benefits.

**POLICY STATEMENT ON INSURANCE BENEFITS:**

I understand that health insurance is an agreement between my insurance company and me to pay a specified amount for medical care. The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the facility of any insurance or other applicable (e.g., Medicare, Medicaid) benefits otherwise payable to or on behalf of the undersigned or patient for these outpatient services at rate not to exceed the regular charges. It is agreed that payment to the physician pursuant to the authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. Any pre-certification of insurance benefits is the patient sole responsibility. The undersigned authorizes payment of Medicare/Medicaid benefits to be made on behalf of the patient of all services furnished by **(CLINIC NAME)** is authorized to bill in connection with its services. It is further understood by the undersigned that he/she is financially responsible for charges not collected by this agreement, unless otherwise stated by applicable written contract or law.

**RELEASE OF MEDICAL RECORDS:**

I authorize the release of medical information to my primary care or referring physician, if needed to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to **(CLINIC NAME)**

**PRIVACY POLICY:**

I undersigned and have had full opportunity to read and consider the contents of this Consent Form and have received a copy of your Notice of Privacy Practices. I understand that, by signing this Consent Form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

\_\_\_\_\_  
*Patient/Parent/Guardian/Conservator/Agent*

\_\_\_\_\_  
*Date:*

\_\_\_\_\_  
*If other than patient, indicate relationship*

\_\_\_\_\_  
*Date:*