HealthMark Patient Registration Form

Patient Information

Last Name	First Name	Middle Initial
Mailing Address		Apt/Unit Number
City/State/Zip		
Home Phone	Cell Phone	Work Phone
Preferred Contact Number	☐ Home ☐ Cell ☐ Work	
Email Address		
Date of Birth	Gender	Marital Status
Social Security Number	Employer Name	
Emergency Contact Name		
Emergency Contact Phone Number	Relationship to Patient	

Race			Ethnicity
☐ Caucasian	☐ Black or African American	☐ Asian	☐ Hispanic or Latino
☐ Hispanic	☐ American Indian or Alaska Native	☐ Native Hawaiian or Pacific Islander	☐ Not Hispanic or Latino
☐ Other	☐ Decline		☐ Decline

Insurance Information

Primary Insurance	Secondary Insurance
Insurance Company Name	Insurance Company Name
Insurance ID Number	Insurance ID Number
Plan/Group Number	Plan/Group Number
Plan Effective Date	Plan Effective Date
Claim Mailing Address	Claim Mailing Address
City/State/Zip	City/State/Zip
Insurance Company Phone Number	Insurance Company Phone Number
Subscriber Name	Subscriber Name
Subscriber Date of Birth	Subscriber Date of Birth
Subscriber Social Security Number	Subscriber Social Security Number
Relationship to Patient	Relationship to Patient

How did you get referred to HealthMark? ____________________

Thank you for choosing us as your healthcare provider. We are committed to providing quality care and service to all of our patients. The following is a statement of HealthMark's office and financial policies, which we require that you read and agree to prior to any treatment.

- Our policy is to charge $50.00 for missed appointments not cancelled at least 24 hours in advance. This charge is solely your responsibility and not your insurance company's. If you arrive late for a scheduled appointment, we reserve the right to ask you to reschedule.
- Our on-call providers are available after hours for urgent and emergency situations. Non-urgent calls placed to the on-call provider may be charged a $30.00 phone consultation fee. This charge is solely your responsibility and not your insurance company's.
- Plan ahead for prescription refills. Contact your pharmacy directly to request a refill and allow up to 3 days for the pharmacy to contact us and for us to respond.
- Plan ahead for referrals. Allow up to 5 days for non-emergency referrals to be processed.
- Our providers will not diagnose, treat, or prescribe medication over the phone or online.
- Payment of your bill is considered part of your treatment. It is your responsibility to pay co-pays, co-insurance, and/or deductibles on the day of service, and to pay any other balance not paid for by insurance. We accept cash, checks, credit cards, and insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable. Self-pay patients must pay for services on the day on which they are rendered.
- It is your responsibility to know your own insurance benefits. This includes knowing your covered benefits, any exclusions in your insurance plan, any pre-authorization requirements of your insurance plan, and whether we are a contracted provider with your insurance company.
- It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance.

I have read the policies contained above, and my signature below serves as acknowledgement of a clear understanding of my responsibilities. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature of Patient/Responsible Party ______________________ Date ______________

Please Print Name of Patient/Responsible Party ______________________ Relationship to Patient ______________

I have reviewed a copy of HealthMark's Notice of Privacy Practices.

Signature of Patient/Responsible Party ______________________ Date ______________