

REGISTRATION

(Please Print)

Timarron Family Medicine, PA

200 Pecan Creek Dr
Southlake, TX 76092
PH: 817-481-4739 FAX: 817-481-5198

PATIENT INFORMATION

Date: _____ Email: _____

Name of Patient: _____
(Last) (First) (Middle)

Home Address: _____
(Street) (Apt. No.) City State Zip

Home Phone: _____ Cell/Work Phone: _____ D.O.B. _____

SS# _____ Marital Status: Minor Single Married Separated Divorced Widowed

Sex: M or F Occupation: _____ Employer: _____

Emergency contact name: _____ Ph#: _____ Relationship to patient: _____

INSURANCE INFORMATION

Primary Ins. Name: _____
Ins. Address: _____

Secondary Ins. Name: _____
Ins. Address: _____

Ins. Phone: _____

Ins. Phone: _____

Group #: _____ Copay\$ _____

Group#: _____ Copay\$ _____

ID/Policy#: _____

ID/Policy#: _____

Policy issued to: _____

Policy Issued to: _____

Insured's address & PH#: Same as above

Insured's address & PH#: Same as above

Insured's DOB: _____

Insured's DOB: _____

Insured's SS#: _____

Insured's SS#: _____

Relationship to patient: _____

Relationship to patient: _____

Employer: _____

Employer: _____

Thank you for selecting Timarron Family Medicine as your health care provider! We appreciate the opportunity to assist you with your health care needs.

All copays & deductible amounts are due at time of service. We accept cash, personal checks, or MasterCard & Visa. There will be a \$25 charge for all returned checks. Your services are filed to your insurance within 2 working days of your visit and payment from your insurance is expected within 45 days. If you are not on one of the managed care programs that we are providers for, or this is a third party billing situation, payment is expected at time of service. We will provide you with a billing statement that contains the necessary information for you to file your insurance claims for reimbursement.

If there is a balance due on your account, monthly statements are sent from the office. If an account falls over 90 days old and there has not been an attempt by the patient or legal guardian to make payment arrangements, or failure to comply the arranged payment schedule, the account may be turned over to a collection agency.

It is up to you to know your insurance coverage and keep us notified of any changes in your insurance plan. If services are denied payment from your insurance company as non-covered services, or you have failed to give us your current insurance card, you will be responsible to pay for those charges.

I consent to treatment for the care of the patient indicated on this registration form. I hereby authorize assignment of all medical insurance benefits to Timarron Family Medicine for services rendered. Authorization is hereby granted to release information as may be necessary to process and complete my insurance claims. I also authorize release of information necessary to complete referrals to other facilities for additional testing or other doctors for specialized services and care as deemed necessary by my primary physician.

Date: _____ Signed: _____

(Patient or legal guardian if patient is a minor)