

# PATIENT REGISTRATION

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I hereby assign all medical benefits to which I am entitled (except Medicare), including private insurance and any other health plans to Dr(s). Shoden or Williams. I also authorize Dr(s). Shoden or Williams to be my personal representative, which allows Dr(s). Shoden or Williams to (1) submit any and all appeals when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, and (3) initiate formal complaints to any State or Federal agency that has jurisdiction over my benefits. I understand and agree that I am responsible for FULL payment of the medical debt if my insurance company has refused to pay 100% of my benefits, within ninety (90) days of any and all appeals or requests for information. I also understand that if I do not pay my balance due after insurance reimbursement and the account is sent to a collection agency that I will be responsible for the payment of the 10% interest in addition to the full outstanding balance owed to Dr(s). Shoden or Williams practice.

(Patient's signature or authorized person)

Today's Date

Patients's D.O.B.

Age

Patient's Name \_\_\_\_\_ SS# \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Patient's Employer \_\_\_\_\_

Marital Status: (Circle One):    Single            Married            Divorced            Widowed            Minor            Partner

Patient's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Referring Doctor \_\_\_\_\_

## INSURANCE INFORMATION

Insured's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ SSN# \_\_\_\_\_

Patient's Relationship to Insured:(circle One)    Self    Spouse    Child    Other - Insured's Employer \_\_\_\_\_

Medicare # \_\_\_\_\_ Medicaid # \_\_\_\_\_

Primary Company Name \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance Co. Name \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Insured's Name \_\_\_\_\_

Patient's Relationship to Insured: (circle One)    Self    Spouse    Child    Other \_\_\_\_\_

### Name of friend or nearest relative NOT living with you:

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Do we have your permission to leave a message with PHI on your answer machine at home?    Yes \_\_\_\_\_ No \_\_\_\_\_

Leave a message on your cell phone? Yes \_\_\_\_\_ No \_\_\_\_\_ Leave a message on your work voice mail? Yes \_\_\_\_\_ No \_\_\_\_\_