

**PATIENT REGISTRATION** (Please Print and fill out both sides of form)

**PATIENT: THIS SECTION REFERS TO PATIENT ONLY**

Name: Last	First	Middle	Sex:	Age:	Birth Date:	Marital Status (X one)	
Address:			Apt. #:		Social Security #:	<input type="checkbox"/> Single	<input type="checkbox"/> Married
City:			State:	Zip:	Employer:	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated
Home Phone:			Occupation:				
Alternate Phone:			Employer's Address:		Work Phone		
Reason for visit:			City:		State:	Zip:	
Name of Referring Physician or PCP:					Phone #:		

<b>Emergency Contact</b> (not living with you)	Name:		
Relationship to patient:	Phone #:	Work #:	

**PARENT, SPOUSE OR OTHER PERSON RESPONSIBLE FOR BILL:**

Name:	Relationship to Patient:	Birth Date:
Address:		Social Security #:
City:	State:	Zip:
Home Phone:	Employer Address:	
Work Phone:	City:	State: Zip:

**INSURANCE INFORMATION**

<b>ACCIDENT DETAILS:</b>			
Date:	Time:	Did this injury occur at work?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, where?
What happened?			
Signature		Date	

**IF WORKMEN'S COMP. Complete**      **IF MOTOR VEHICLE OR OTHER ACCIDENT Complete**

Name of Ins. Co.:	Name of Ins. Co.:
Address:	Address:
City	City
State	State
Zip	Zip
Phone #:	Phone #:
Claim #:	Claim #:
Date of Injury	Date of Acc:
Claim Rep name:	Ins. Adjuster name:

**PRIMARY INSURANCE**      **SECONDARY INSURANCE**

Name of Ins. Co.:	Name of Ins. Co.:
Address:	Address:
City	City
State	State
Zip	Zip
Phone #:	Phone #:
ID #:	ID #:
Group #:	Group #:
Effective Date:	Effective Date:
Co-pay:	Co-pay:

**PLEASE READ THE FOLLOWING CAREFULLY:**

**Paul D. Ruesch, M.D., P.C., Matthew T. Sugalski, M.D., P.C. & Bret T. Kean, M.D., P.C., Geoffrey E. Baum, D.O.  
Clinic Policy & Patient Information Sheet**

- **CO-PAYS ARE DUE AT THE TIME OF SERVICE.** We accept Visa, MasterCard, cash or check for all payments.
- Please inform us if your insurance carrier requires **prior authorization or referrals** for office visits, diagnostic tests, hospital confinement, or surgery. Noncompliance could result in your financial responsibility.
- **A \$100 deposit is due at the time of service for uninsured or out of plan patients.** Motor Vehicle claims will be billed as a courtesy; however, the balance is still your responsibility and must be paid within 60 days, regardless of pending litigation.
- **A \$100 deposit is due for failure to provide insurance information** at the time of service, or your appointment can be rescheduled.
- **1.5% interest will be charged per month** on any unpaid balance over 60 days old. This will be waived in the case of monthly budget payment in excess of 10% of the fee charged at the time of service.
- **On-the-job injuries must be declared at the time of service.** You must fill out an 827 form for each new injury and also an 801 form with your employer. We will not accept closed claims or claims with injuries over 1 year old.
- **A \$10 fee will be charged for filling out disability and income insurance forms.** These should be turned into the Front Office, not the doctor and will be mailed directly to the insurance carrier.
- Every effort will be made to **return your phone calls within 24 hours.** Please provide day and night numbers where you can be reached.
- **Prescription refills are handled by your pharmacy. DO NOT CALL THE OFFICE;** contact your pharmacy in the morning. Requests will be forwarded to our office and dealt with after 5:00 p.m. Contact your pharmacy after 7:00 pm to find out if your refill has been approved. We do not refill at nighttime or on weekends. Please allow 24 to 48 hours for your refill request.
- Pain medication may be prescribed for up to 3 months after surgery or injury, after which time you should get medication from your primary care provider, unless you are still being treated by this office.
- **A \$25 charge will be assessed after a second no-show appointment,** unless cancelled 24 hours prior to appointment.
- We will bill your primary and secondary insurance as a courtesy; however, deductible and co-insurance payments are your responsibility and must be paid within 30 days of billing.
- If you have financial problems interfering with prompt payment, notify the office staff. We may be able to assist you with a payment plan.
- I hereby acknowledge and understand if I am scheduled for a surgical procedure that my procedure may be performed at a center that is partly owned by one of the physicians named above.

**Contractual Agreement to Pay Medical Expenses**

I hereby authorize Paul D. Ruesch, M.D., P.C. and/or Matthew T. Sugalski, M.D., P.C. and/or Bret T. Kean, M.D., P.C. and/or Geoffrey E. Baum, D.O. to submit a claim to my insurance carrier or its intermediaries for all services rendered by Paul D. Ruesch, M.D., P.C. and/or Matthew T. Sugalski, M.D., P.C. and/or Bret T. Kean, M.D., P.C. and/or Geoffrey E. Baum, D.O. and direct my insurance carrier or its intermediaries to issue payment check(s) directly to Paul D. Ruesch, M.D., P.C. and/or Matthew T. Sugalski, M.D., P.C. and/or Bret T. Kean, M.D., P.C. and/or Geoffrey E. Baum, D.O.

I hereby authorize Paul D. Ruesch, M.D., P.C. and/or Matthew T. Sugalski, M.D., P.C. and/or Bret T. Kean, M.D., P.C. and/or Geoffrey E. Baum, D.O. to release all information necessary regarding services rendered.

I understand that I am responsible for all charges not covered by said insurance. This will prevent further misunderstanding. Please note that accounts over 30 days old are considered delinquent and are subject to a \$5.00 rebilling fee per statement cycle. Accounts over 60 days old are considered collections problems and will be handled as such. Please feel free to discuss your account at any time.

I understand I am responsible for obtaining any referral or prior authorization which may be required by my insurance plan.

By signing below, I agree that I have reviewed and understand the information above and that a copy of the Notice of Privacy Practices and Office Policies is available upon request. I further understand that I am financially responsible for all charges whether or not paid by my insurance.



\_\_\_\_\_  
Patient's Signature (Parent or guardian if patient is a minor)

\_\_\_\_\_  
Date of signature