



## PATIENT REGISTRATION

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_ Zip Code: \_\_\_\_\_ - \_\_\_\_\_

Home Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Fax: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Cell Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-mail: \_\_\_\_\_

Social Security No.: \_\_\_\_/\_\_\_\_/\_\_\_\_ Driver's License No.: \_\_\_\_\_ State: \_\_\_\_\_

Marital Status: Single  Married  Widowed  Separated  Divorced  Other  Sex: M  F

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Referred by: \_\_\_\_\_ Dr.  Friend  Other  \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### RESPONSIBLE PARTY/PRIMARY INSURED (IF NOT PATIENT)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Last First Middle

Address: (if different from patient's): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insurance Co.: \_\_\_\_\_ Policy No.: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ - \_\_\_\_\_

### AUTHORIZATION TO RELEASE INFORMATION AND CONSENT FOR TREATMENT

I consent to care and treatment by **Johnson Medical Associates, P.A.** as may be prescribed by same and/or dictated by professional standards. The nature, purpose, benefits, and risks of all care and service have been explained to me. I authorize the release of patient health information (PHI) in order to carry out the treatment, payment of healthcare operation (TPO) to the practice of **Johnson Medical Associates, P.A.** Treatment includes the provision, coordination or management of healthcare and related services by one or more healthcare providers, or the referral of a patient for healthcare from one provider to another. Payment means the activities conducted by the practice to obtain reimbursement for healthcare services. This includes, among others, billing, claims management, collection activities, verification of insurance coverage, and pre-certification of services. If I am a person different from the patient, this authorization is on the patient's behalf and is permission to use a copy of this authorization in place of the original.

**Insurance Filing:** Some of the procedures we provide are not covered by most insurance companies, and may be deemed as "not medically necessary" and non-reimbursable. We will provide medical records at the request of your insurance company after their receipt of the insurance claim form you submitted. Our office is unable to provide any additional assistance in obtaining reimbursement for services provided.

### FINANCIAL AND MEDICARE POLICIES

**PAYMENT IS EXPECTED AT TIME OF SERVICE.** We will provide you with the necessary forms to file with your insurance provider. We accept **VISA, MasterCard, American Express, and Discover.**

**MEDICARE POLICY:** If **Johnson Medical Associates, P.A.** determines that the services provided do not meet the requirements for coverage under Medicare, I verify that I received a MEDICARE WAIVER informing me of this possibility. As a non-participating Medicare provider, patients are charged the limiting charge for covered services at the time rendered. Non-covered services will be charged at our standard office rates.

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

Tel: 972-479-0400 | 101 S. Coit Rd. Ste. 317 | Richardson, Texas 75080 | Fax: 972-479-9435  
www.johnsonmedicalassociates.com