

Efrain Garcia, M.D., P.A.

PATIENT REGISTRATION

Name: _____

Last

First

Initial

Address: _____

City: _____ State: _____ Zip: _____

Home: _____ Cell: _____

Fax: _____ Cell: _____

Soc. Sec. #: _____ Date of Birth: _____ Age: _____

Email address: _____

EMPLOYMENT INFO

Employer: _____ Work phone #: _____

Occupation: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone #: _____

Referred by: _____

INSURANCE INFORMATION

Insurance Company: _____

Tel. #: _____

Group #: _____ Policy #: _____ Eff. Date: _____

Inured name: _____

Relationship: _____

Secondary Insurance _____

Policy #: _____ Group #: _____

PLEASE PRESENT INSURANCE CARD AND PICTURE I.D.

PAYMENT IS EXPECTED AT THE TIME OF SERVICE FOR ANY CHARGES NOT COVERED BY YOUR INSURANCE.

I HEREBY AUTHORIZE THE DOCTOR TO RELEASE INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS:

INITIALS: _____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN FOR SERVICES RENDERED:

INITIALS: _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

DATE

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Missed Appointment/Late Cancellation Fee Agreement

I agree that:

My appointment has been reserved exclusively for me. I understand that I am required to cancel this appointment **24 hours prior** to my appointment time.

In the event that I do not cancel my appointment 24 hours prior to my appointment time I understand that I will be charged a Missed Appointment/Late Cancellation Fee.

I also understand that my insurance company is not responsible for late fees that are incurred for missed appointments/late cancellations and that it would be unethical or illegal for this office to bill my insurance for these fees.

Therefore, I understand and agree to pay this fee in accordance with office policy in effect at the time.

Patient Signature

Date

Acknowledgement of Receipt of Privacy Notice

I acknowledge that I have received the attached Privacy Notice.

Patient or Personal Representative Signature

Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

If unable to sign above, document reason:

I certify that the above explanation is true and correct,

Witness

Printed Name

Witness

Printed Name