

Kirk C. Casey, M.D.

REGISTRATION FORM

PATIENT NAME _____ REFERRED BY: _____
LAST FIRST INITIAL
HOME ADDRESS _____ DATE OF BIRTH ____ / ____ / ____ MALE FEMALE
HOME PHONE (____) _____
MAILING ADDRESS _____ CELL PHONE (____) _____
OK TO LEAVE MESSAGES AT HOME: YES / NO DRIVERS LIC. NO. _____
EMPLOYER _____ CREDIT CARD NO. _____ EXP. _____
EMPLOYER PH# (____) _____ SOCIAL SECURITY # _____
OK TO LEAVE MESSAGES AT WORK: YES / NO MARITAL STATUS S M W D SEP

SPOUSE/GUARDIAN _____ DATE OF BIRTH ____ / ____ / ____
LAST FIRST INITIAL
SPOUSE ADDRESS _____ HOME PHONE (____) _____
(IF DIFFERENT)
EMPLOYER _____ DRIVERS LIC. NO. _____
EMPLOYER PH# (____) _____ SOCIAL SECURITY # _____
NAME OF PERSON RESPONSIBLE FOR BILL _____ RELATIONSHIP TO PATIENT _____
MAILING ADDRESS _____ PHONE (____) _____
EMERGENCY CONTACT NOT LIVING WITH YOU _____ RELATIONSHIP _____ PHONE (____) _____

PLEASE PRESENT YOUR INSURANCE CARDS WITH THIS COMPLETED FORM
SO THEY MAY BE SCANNED FOR YOUR MEDICAL RECORD.

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I authorize Kirk C. Casey, M.D. and physician in charge of patient's care to perform all necessary and advisable medical procedures for diagnosis and treatment. I understand that I will be informed of all proposed medical procedures or treatment prior to commencement, except in case of emergency. I also understand that I have the right to refuse any proposed medical procedure or treatment.

I assign to and approve direct payment to Kirk C. Casey, M.D. of any insurance benefits otherwise payable for patient's treatment. However, I fully understand that I am financially responsible to Kirk C. Casey, M.D. for the charges not covered by this assignment.

In the event it becomes necessary for Kirk C. Casey, M.D. to refer me to another facility or physician for additional tests, X-rays or medical care, I authorize them to release all medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my impairment(s), including psychological or psychiatric impairment(s), drug abuse, alcoholism, sickle cell anemia, acquired immunodeficiency syndrome (AIDS), or tests for or infection with human immunodeficiency virus (HIV).

MEDICARE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I request that payment of authorized Medicare benefits be made on my behalf to Kirk C. Casey, M.D. for any services furnished me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information to pay the claim. If item 9 of the HCFA-1500 form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

DATE _____ SIGNED _____