INJURY CARE
MEDICAL CENTER

Patient Registration Form

Patient Name_____
First Middle Last

Address (Street) _____

Address (city, state, zip)_____

Phone (home) _____ (work)_____ (cell) _____

Email _____

Emergency Contact _____ Phone _____

Social Security Number _____ Date of birth _____

(Required to process insurance claims)

Insurance Information

Guarantor (The person who holds the insurance policy) O Self O Parent O Spouse

Guarantors Name _____ Guarantor's date of birth _____

Guarantor's Employer _____ Social Security # _____

Patient's Employer _____

Primary Insurance Company Name: _____ Group # _____

Insurance Policy number _____

Secondary Insurance Company Name: _____ Group # _____

Insurance Policy number _____

Authorization for Payment of Insurance Benefits

I authorize payment directly to Dr. Radnovich, D.O., P.C, doing business as Injury Care Medical Center (hereafter 'Provider'), for all charges for medical products and services. I understand that I am financially responsible to Provider for all charges and that he will bill the insurance company for my convenience. I further understand that medical decisions are made between the doctor and the patient. And that some insurance companies might call some treatments "medically unnecessary" without regard for what the doctor and patient have determined. Some procedures our doctors perform, although they have shown to be safe and effective, are considered "experimental" by insurance companies and are not covered. I authorize Provider to provide information, including my medical information, to the insurance company and to explain our treatment plan. I understand that I am responsible for these charges if the insurance company denies my claim for any reason. I understand that it is my responsibility to verify if my insurance will cover certain procedures or services. If I am a Medicare patient, I will be told in advance if a service or procedure is known not to be covered and will submit payment at the time of service or procedure.

Health Insurance & Medicare Assignment

I hereby request that the payment of authorized benefits for services rendered or in my behalf by Provider, be made to Provider. I authorize any holder of medical information about me to release it to the Healthcare Financing Administration, my insurance carrier or its agents, any information (in compliance with HIPPA and other regulations) as required to determine these benefits or the benefits payable for related services.

Patient Signature _____

Guarantor Signature _____Date_____