pinnacle
MEDICAL GROUP, INC.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

PATIENT'S LAST NAME	FIRST	MI	MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED	DATE OF BIRTH	AGE	SEX

PATIENT'S ADDRESS	APT/SPACE #	CITY	STATE	ZIP	HOME PHONE NO.	SOCIAL SECURITY NO.

MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	OTHER NAMES USED

PERSON RESPONSIBLE FOR PATIENT'S EXPENSE

NAME LAST	FIRST	MI

ADDRESS	DATE OF BIRTH

CITY	STATE	ZIP

RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	PHONE NO.

EMPLOYER

NAME

ADDRESS

CITY	STATE	ZIP

PHONE NO.	OCCUPATION

SPOUSE OF PERSON RESPONSIBLE

NAME LAST	FIRST	MI

ADDRESS	DATE OF BIRTH

CITY	STATE	ZIP

RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	PHONE NO.

SPOUSE'S EMPLOYER

NAME

ADDRESS

CITY	STATE	ZIP

PHONE NO.	OCCUPATION

EMERGENCY CONTACT

NAME	RELATIONSHIP TO PATIENT

CITY	STATE	PHONE NO.

EMERGENCY CONTACT

NAME	RELATIONSHIP TO PATIENT

CITY	STATE	PHONE NO.

INSURANCE INFORMATION

	PRIMARY	SECONDARY
Insurance Name		
Subscriber's Name		
Subscriber's SSN		
Subscriber's DOB		
Subscriber's Emp.		
Relationship to Pt.		

MARKETING INFORMATION

How did you hear about Pinnacle Medical Group?

☐ 1. Newspaper ☐ 2. Friend or Family ☐ 3. Health Fair

☐ 4. Insurance or Employer ☐ 5. Radio ☐ 6. Yellow Pages

Please check all that apply.

FOR OFFICE USE ONLY

Account #: _____ Chart #: _____

Location: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT AND MEDICAL RECORDS RELEASE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize any holder of medical information about me to release said medical information requested by insurance companies with whom I have coverage or any public agency and it's agents to determine benefits for services provided or benefits for related services.
ASSIGNMENT OF BENEFITS: I hereby authorize payment of benefits be made directly to Pinnacle Medical Group for services provided to me by Pinnacle Medical Group. I understand that I am financially responsible to Pinnacle Medical Group for charges not covered by this assignment. I authorize refund of overpaid insurance benefits where my coverages are subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees.
This authorization will remain in effect until revoked in writing by the undersigned.

Date

Signature of Patient - If minor, then signature of responsible person.

FINANCIAL DISCLOSURE STATEMENT

Pinnacle Medical Group, Inc.

The following disclosure is furnished in compliance with the Federal Truth-In-Lending Act.

Pinnacle Medical Group shall charge a FINANCE CHARGE on any part of the "previous balance" as shown on the periodic statement from the group, which remains unpaid in excess of 60 days after the first billing of the "previous balance" at the periodic rate of 1¼% per month after deducting current payments and/or credits received prior to the closing (billing) date of the statement. The ANNUAL PERCENTAGE RATE is 15% per annum. There shall be in all cases a minimum FINANCE CHARGE of $.50 per month. Said minimum charge may result in an ANNUAL PERCENTAGE RATE in excess of 15% per annum. No FINANCE CHARGE will be charged on any "previous balance" as shown on the periodic statement, which is paid 60 days from the first billing of the "previous balance" or on any current charges listed on the periodic statement. The FINANCE CHARGES are figured on your account by applying the periodic rate to the amount you owe at the beginning of each billing cycle. All payments received shall be first applied to any FINANCE CHARGE assessed to the account, and then to that portion of the "previous balance" which is more than 60 days unpaid and then to that portion of the "previous balance" which is less than 61 days unpaid and then to the current charges listed on the periodic statement, and finally to credit.

You may pay your entire balance at any time.

Any credit balances of $5.00 or less will be automatically adjusted to $0.00 due to the administrative costs of processing balances.

You are responsible for payment on your account regardless of insurance. Pinnacle Medical Group, cannot accept the responsibility for collecting your insurance claims or negotiating a settlement on a disputed claim. Notwithstanding insurance benefits that may have accrued, the FINANCE CHARGES as set out above shall be assessed against all accounts, even if the account will ultimately be paid by insurance benefits.

Pinnacle Medical Group will not acquire or retain any security interest in any property to secure the payment of credit extended for services rendered, except that Pinnacle Medical Group reserves the right to obtain assignment of benefits for payment of balances accrued at the group.

I certify that I have read this statement and have had an opportunity to review with the group personnel any questions I may have had regarding the same.

Patient's Signature _____ Date _____

Pinnacle Medical Group, Inc.
CONSENT FOR TREATMENT

1. I hereby do voluntarily consent to such care including routine procedures and other treatment by Pinnacle Medical Group professionals and their assistants, appointees, or Consultants as is necessary in their judgement.

2. I am aware that the practices of medicine, surgery and other health disciplines do not constitute exact sciences and I acknowledge that no guarantees have been made to me as to the result of treatments or examination in Pinnacle Medical Group.

3. I understand that for certain procedures deemed necessary by my physician I will be required to sign a Special Consent Form. Further, if I don't fully understand a procedure or its risks, consequences, and alternate methods of treatment, I have the right to question the appropriate health care professionals.

4. I understand that Pinnacle Medical Group shall not be responsible or liable for the loss of/or damage to any personal property.

5. I authorize the release to any party responsible for my care, such information from my records as is required in order for the group and all entities providing services to obtain payment. This includes records of alcohol and drug abuse and/or treatment, records of psychological services and social services, including communications made by the patient to a physician, social worker, or psychologist. This authorization shall be effective only so long as necessary to obtain payment or reimbursement and will end when payment or reimbursement is received.

I have read the above statement and my questions have been adequately answered and I certify that I understand its contents.

Print Patient Name _____ Date of Birth _____

Signature of Patient _____ Date _____

Signature of Parent or Guardian _____ Date _____

I have received information regarding my rights concerning the Durable Power of Attorney for Health Care.

Initial Here: _____