

# David Alessi, M.D., F.A.C.S.

# Anna Hsu, M.D.

## Patient Registration Form

<b>Name</b>		<b>Date of Birth</b>	<b>Age</b>	<b>Sex</b>
<b>Address</b>		<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Home Phone #</b>	<b>Work Phone #</b>	<b>Emergency Contact Info</b>		
	<b>Driver's Lic. #</b>	<b>E-Mail Address</b>		
<b>Occupation</b>	<b>Employer</b>	<b>Work Phone #</b>		
<b>Name of Spouse(for children)</b>				
<b>Occupation of Spouse</b>		<b>Spouse's Employer</b>	<b>Work Phone #</b>	
<b>Emergency Contact Name</b>			<b>Phone #</b>	
<b>Name of a Friend/Relative</b>			<b>Phone #</b>	
<b>Primary Insurance Holder Info</b>	<b>Name</b>	<b>Date of Birth</b>	<b>Social Security #</b>	
<b>Referred By</b>			<b>Phone #</b>	
<b>Primary Physician</b>			<b>Phone #</b>	
<b>Dentist</b>			<b>Phone #</b>	

### FINANCIAL POLICY

Dear Patient,

Thank you for choosing us as your health care provider. We are committed to provide you with the best medical care services. The following information is intended to prevent uncertainties in regards to our financial policy. Our practice firmly believes that a good doctor-patient relationship is based upon understanding and good communications.

#### INSURANCE

**We are out of network for all insurances unless written below.** As a courtesy, our practice will review your insurance coverage, estimate your insurance company payment, review your insurance form, and file your claim with your insurance carrier. You will be responsible for any portion of your bill which is denied or not paid by your insurance carrier. Your insurance coverage is a contract between you and your insurance carrier. If an insurance problem occurs, you will be asked to assist us in contacting your insurance carrier. We feel it is necessary to work together to resolve any insurance problem.

#### DEDUCTIBLE

Your deductible will be verified at the time of service and if you have not met your deductible, you are required to pay at the time of service. All Medicare patients have a yearly deductible of \$100.00. Payment for services which qualify toward the yearly deductible begin on January 1st and conclude on December 31st of each year. For example, if your yearly deductible is \$200.00, you must first pay the initial \$200.00 to satisfy your deductible. The discount you receive from your insurance company will be calculated when we receive the explanation of benefits for your service and any adjustments will be made at the time.

#### CO-PAYMENT

All co-payments must be paid at the time of service.

In Network For \_\_\_\_\_

#### METHOD of PAYMENT

Please let us know what method you will be using: CASH, CREDIT CARD, or CHECK.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS. I hereby authorize Dr. David M. Alessi, M.D., F.A.C.S. or Dr. Anna Hsu, M.D. to furnish information to insurance carriers concerning this illness and the treatments I receive, and I hereby irrevocably assign to the doctors all payments for medical services rendered. I understand that I am financially responsible for all charges not covered by my insurance benefits. I also authorize that photographic copy of this authorization is as if such copy were original. I also authorize the doctors to file a formal written complaint with the insurance commissioner if my insurance fails to pay or deny a claim within 30 days.

I have read, understood and agree to the provisions of this form.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_