Reiter, Hill and Johnson, P.L.L.C.

Mark B. Reiter, M.D., F.A.C.O.G. • Charles F. Hill Jr., M.D., F.A.C.O.G. • M. Melody Abraham, M.D., F.A.C.O.G. • Paula M. Radecki, M.D.
Shiva Sedghi, M.D., F.A.C.O.G. • Heather L. Johnson, M.D., F.A.C.O.G. • Kirstiaan L. Nevin, M.D., F.A.C.O.G. • Amanda Herrin McPherson, M.D.
Lauren Muangman, M.D., F.A.C.O.G. • Kristen Matsik, M.D., F.A.C.O.G. • Joan Loveland, M.D., F.A.C.O.G. • Caro Garlich, M.D.
M. Lauren Lemieux, C.R.N.P. • Noelle Soobert, P.A. C. • Mona Milberg, R.N.C., F.N.P. • Sharon G. Frisch, R.N., C.N.M. • Margaret King, O.G.N.P.

Patient Registration – *Please Print Clearly* **Today's Date**

Patient Name First Middle Last					Date of Birth	Age
Home Address Apt #		City		State	Zip Code	
Occupation Employed ☐ Retired ☐ Student: ☐ FT ☐ PT		Social Security #	Marital Status	Sex	Home Phone	
Employer (or previous employer, if retired)		Address			Work Phone	
Spouse (or Parent) Name		Spouse (or Parent) Address			Patient Cell Phone	
Spouse (or Parent) Employer		Spouse (or Parent) Home Phone			Spouse (or Parent) Work Phone	
Nearest Relative/Friend (Contact in Case of Emergency)		Relationship	Home Phone		Work Phone	
Relative/Friend Address						
Referring Physician		Address			Telephone	

Policy Concerning Payment of Medical Bills

Many HMO and PPO Insurance carriers require that a patient obtain a referral form or authorization prior to an examination by a specialist. It is *your* responsibility as a patient to obtain a referral and/or authorization number prior to your visit to our office. Your insurance plan may not pay for services rendered without a referral form or authorization number. Should you choose to receive services without the required referral form or authorization number, you will be held responsible for any charges incurred.

I have read the above paragraph and understand that failure to present a referral form or authorization number for services rendered in the office, if required by my insurance plan, will result in my being held responsible for payment of any charges incurred. This applies to service provided on this date as well as service that may be provided in the future.

Our policy requires payment to be made at the time of services are rendered. Whether or not your insurance company pays in full, a portion or no portion of your medical bills is a matter between you and your insurance carrier. Unless other arrangements have been made, any unpaid balances are due within 30 days of treatment. Payment is accepted in the form of cash, check, credit card or money order.

I agree to promptly pay all charges when billed for medical services rendered
and accept legal responsibility for any and all charges for the patient named above. **X**_____

Primary Insurance	Insurance Company Name		ID or Policy Number	Group/Code
	Insurance Company Address		Subscriber's Social Security #	Date Effective
	Subscriber's Name	Sex	Home Phone	Relationship to Patient
	Subscriber's Address		Work Phone	Subscriber's Date of Birth
Secondary Insurance	Insurance Company Name		ID or Policy Number	Group/Code
	Insurance Company Address		Subscriber's Social Security #	Date Effective
	Subscriber's Name	Sex	Home Phone	Relationship to Patient
	Subscriber's Address		Work Phone	Subscriber's Date of Birth

Patient Authorization

I, _____, hereby authorize Drs. Reiter, Hill and Johnson, P.L.L.C., to apply for benefits on my behalf for covered services rendered. I request payment from Care First Blue Cross Blue Shield, Medicare, and/or _____ Insurance Company be made directly to the above named provider (or in case of
(Name of Other Insurance Company)
Medicare Part B benefits, to myself or the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration), the insurance company named above and/or my primary care physician. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either the above named carrier or me at any time in writing.

Date_____ Signature of Subscriber_____

Account Number

Initial _____ Date _____
Initial _____ Date _____
Initial _____ Date _____
Initial _____ Date _____