Klein & Associates, M.D., P.A. **Registration Form**

Patient's Last Name _____ First _____MI_____

Social Security # _____ Date of Birth _____

Age _____ Sex M F Family Doctor _____ Referring Doctor _____

Home Address _____

_____ Apt # _____

City _____ State _____ Zip _____

Home Phone ( ) _____

Mobile Phone ( ) _____ Email _____

Patient's Employer _____

Employer's Address _____

_____ Suite _____

City _____ State _____ Zip_____

Work Phone ( ) _____ (Only list if you are able to receive phone calls at work).

Marital Status: Single Married Separated Divorced Widowed

Spouse's Name _____ DOB _____

Social Security # _____ (only necessary if required for insurance claim)

Employer's Address _____

_____ Suite _____

City _____ State _____ Zip Code _____

Spouse's Work Phone ( )_____(Only list if you are able to receive phone calls at work).

Authorization to Release Information for Rheumatology Consultants:

(1) Name _____ Relationship to Patient _____

Phone ( ) _____

(2) Name _____ Relationship to Patient _____

Phone ( ) _____

Signature _____ Date _____

Payment Policy

The patient is responsible for payment at the time of service, unless prior arrangements have been made. Payments can be made either by cash, check or Visa/Master card. If we participate with your insurance company we will file the claim. All patients with insurance that Dr. Klein and Dr. Howell do not participate with, are responsible for payment at the time of service, unless prior arrangements have been made, or they have obtained an out of network authorization before the time of service.

The patient is responsible for any service that is not covered by his/her insurance as well as any co-pays, deductibles, and co-insurance. Co-pays are due at the time of service. We accept co-pays by cash, check or Visa/Master card.

All HMO and Managed Care plans require a referral for all services. **It is the patient's responsibility to obtain any necessary insurance referrals.** If you do not have a referral, your appointment will need to be rescheduled.

Each patient is responsible to make sure that lab studies, x-rays and scans are performed at a facility participating with their insurance.

If a response to a claim is not received from your insurance company within forty-five (45) days after billing, a statement will be sent to you. If your account becomes delinquent and becomes assigned to a collection agency, you agree to pay 35% collection agency fees, court costs, and attorney fees.

A $35.00 returned check fee will be assessed to the account for each check returned to the office as a result of insufficient funds.

We require at least a 24 hour notice to cancel an appointment. If you do not call at least 24 hours ahead of time **or** if you **no show** for an appointment, you will be charged a $50 fee that must be paid before another appointment is scheduled for you.

I hereby authorize Drs. Klein and Howell to furnish information to any insurance company or authorized agency specified concerning my medical care. I hereby assign and transfer any medical benefits due me to Drs. Klein and Howell for the services provided to me by this medical practice. I permit a copy of this authorization to be used in place of the original. Regulations pertaining to Medicare Assignment of Benefits apply, as applicable.

I have read, understand and agree to all of the terms described in the Payment Policy above. I understand and agree, accept where applicable under contract, that I am ultimately responsible for the balance on my account for any professional services rendered.

_____ _____

DATE SIGNATURE

Consent & Assignments

Medicare

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Finance Administration or its intermediaries or carriers of any information needed for this or a related Medicare claim (Title XVIII). I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party whom accepts assignment.

Blue Cross/Blue Shield Of Maryland

Dr. Steven Klein and Dr. Mary Howell are participating physicians of Blue Cross/Blue Shield of Maryland, Inc. I authorize release of any medical information necessary to process this claim. I understand that I am responsible for any deductible and/or co-payment.

Insurance Assignment

I authorize and assign payment directly to the physicians involved in my treatment and authorize release of medical information necessary to process the claim. I further understand I am financially responsible for charges not covered by my insurance.

Managed Care

I understand that without an authorization/referral form from my HMO/IPA/PPO or MCO I will be financially responsible for charges I incur.

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Ultimately, you are responsible for payment to our physicians for services rendered. If your insurance company does not respond to our claim within 45 days, a statement will be sent to you. Your signature below acknowledges your understanding and your agreement to fulfill all financial obligations.

_____ _____

DATE **SIGNATURE**

KLEIN & ASSOCIATES, M.D., P.A.

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____, have received a copy of Klein & Associates, M.D., P.A.'s Notice of
Patient Name

Privacy Practices.

_____ _____

Signature of Patient Date

Current Medication List

Please list below, all prescription and over-the-counter medications as well as any supplements you are currently taking.

Name: _____

Pharmacy: _____

Drug Allergies: _____

Drug Name	**Dosage**	Date Started (if known)