

PATIENT REGISTRATION

If The Patient Is A Child, Fill Out The Information As It Pertains To The Child

Patient First Name (As on insurance card) Last Name M.I.

Male Female Date of Birth Age Student Status: F/T P/T N/A

Social Security #

Street City State Zip

Home Tel. # Business Tel. # Your Cell #

If you are interested in receiving discounts and promotional announcements from Advanced Specialty Care, please provide email address and sign consent below. To opt out at anytime, call 203-791-9661

EMAIL ADDRESS:

Responsible Parent/Guardian Parent/Guardian Date of Birth

Parent/ Guardian Phone

Street City State Zip DOB

Emergency Contact Name: Relationship

Home Tel #: Cell #

Primary Doctor Location (City) (As listed on your insurance card)

Referring Doctor

If your insurance plan requires an insurance authorization referral to this office, you must have this referral at the time of your visit, or full payment will be expected is your responsibility to ensure your authorization referral is current and on file in this office prior to seeing the physician for all visits, including follow-ups.

There are NO exceptions to the office referral policy.

*HSA POLICY-if you have a health savings account insurance plan, and your deductible has not been met, we request payment at time of service, a payment plan can be set up with our billing department. Your office visit can range anywhere from \$150-\$260, to additional testing ranging from \$200-\$800.

PRIMARY INSURANCE COMPANY INFORMATION

Information must be filled in completely, even if we copy your insurance card.

Ins. Co. Name Plan

ID# Group name or Number

Policy Holder's Name Relation to patient

Sex: Male Female Date of Birth Social Security #

Employer Phone #

SECONDARY INSURANCE COMPANY INFORMATION

Ins. Co. Name Plan

ID# Group name or Number

Policy Holder's Name Relation to patient

Sex: Male Female Date of Birth Social Security #

Employer Phone #

Date

ACKNOWLEDGEMENT OF RECEIPT AND ACCEPTANCE OF:

Notice of Privacy Practices

Informed Consent

Practice Financial Policies

ADVANCED SPECIALTY CARE

107 Newtown Road, Danbury, CT 06810
146 Danbury Road New Milford, CT 06776

901 Ethan Allen Highway, Ridgefield, CT 06877
22 Old Waterbury Road, Southbury, CT 06488

Privacy Officer: Jennifer Retter, Business Manager (203) 830-4700 ext. 265

I hereby acknowledge that I was given the opportunity to review this medical practice's **Notice Of Privacy Practices (HIPAA)**, and that I have the right to ask for a paper copy of the Notice to take with me. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

I authorize the person(s) listed below to discuss my medical information. **If you do not speak English please list the name and phone number of who we can call to discuss your medical information with.**

Name & phone number

Relationship to Patient

Name & phone number

Relationship to Patient

Please note that ASC employees may discuss payment issues with family members or other personal representatives, including the subscriber of my insurance plan, unless I request special privacy protections. My signature on this form authorizes such financial discussion.

Under certain circumstances, this office may need to request lab reports, radiology reports, or other diagnostic test results from outside facilities. At times these facilities may require an authorization to release such records. My signature authorizes the release of any diagnostic test results that we may require in order to provide treatment.

I understand that no procedure provided by this facility is completely without risk and I authorize the care and treatment provided to me under the general or specific directions of my physician or my physician assistant.

If this office does not have a contract with my insurance company, payment must be made at the time of visit unless prior arrangements have been made with the office manager. For patients with coverage that we participate with we will file your insurance claims to your primary carrier for all services and procedures we provide. It is your responsibility to secure all referrals and authorizations required by your health plan and to be aware of its coverage and benefits. All charges are your responsibility from the date the services are rendered. I understand that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. If payment is not received in a timely manner, my account will be turned over to a collection agency. I agree to notify the office of Advanced Specialty Care of any changes to my insurance coverage so that filing my claim is expedited.

Signature (Parent or Guardian if Patient a Minor)

Relationship To Patient

Please Print Name

_____/_____/_____
Date

Patients Name (if Minor)

_____/_____/_____
Patient's date of birth