



# PATIENT REGISTRATION INFORMATION

DATE.....

Please print clearly . . .

## PATIENT INFORMATION [Be sure to use *legal* name]

Name..... Birth Date.....  
(Last) (First) (MI)

Have you ever used a different last name? (circle one) Yes No

If yes, name used..... (including maiden name)

Marital Status: S M D W Sex: M F Social Security # (SSN).....

Address..... Apt. No.....

City..... State..... Zip Code..... Home Ph.....

Your Employer..... Occupation.....

Employer Address..... Employer Ph.....

City..... State..... Zip Code..... Ext.....

## SPOUSE'S INFORMATION

If married, Spouse's name..... SSN.....

Spouse's Birth Date..... Spouse's Employer.....

Employer Ph..... Ext.....

## NAME OF RESPONSIBLE PARTY [Complete if *different* from patient or spouse] [For minor child, list adult with whom child resides or has custody]

Name..... Relationship to Patient.....  
(Last) (First) (MI)

Address..... Home Ph.....

City..... State..... Zip..... SSN.....

Employer..... Employer Ph.....

## EMERGENCY CONTACT [Outside your home and other than above]

Name..... Relationship to Patient.....

Emergency Ph.....

PRIMARY CARE PHYSICIAN ..... ALLERGIES .....

## **PAYMENT AGREEMENT AND AUTHORIZATION**

### ***Danville Polyclinic, Ltd.***

Thank you for choosing Danville Polyclinic, Ltd. as your health care provider. The following is our Payment Agreement and Authorization which must be signed prior to receiving treatment. All patients must complete the Patient Registration form prior to receiving treatment at our facility. In consideration of receiving medical care and treatment, the "Patient" or "Responsible Party" and Danville Polyclinic, Ltd., a corporation organized and existing in accordance with the laws of the State of Illinois (hereinafter referred to as "Danville Polyclinic"), hereby agree that the Patient/Responsible Party guarantee(s) payment in full of any and all charges at the rates established by Danville Polyclinic for the medical care and treatment rendered and materials furnished to or on behalf of the Patient/Responsible Party by Danville Polyclinic, and the Patient/Responsible Party also agrees with Danville Polyclinic to the following terms:

**Payment:** The Patient/Responsible Party may obtain medical care and treatment from Danville Polyclinic from time to time, the charges for which will be added to the account and such services shall consist of all charges incurred at the rates established by the Danville Polyclinic for medical care and treatment rendered to or for the Patient by the Danville Polyclinic. Patient/Responsible Party is responsible for payment regardless of whether an insurance company(ies) or plan(s) determines that a different amount should be charged, unless Danville Polyclinic has a separate written agreement with that insurance company(ies) or plan(s). The Patient hereby appoints his/her attending physician or consulting physician as the Patient's/Responsible Party's agent to execute all written orders for the furnishing of such medical care and treatment which shall be repayable as provided for in this Agreement.

**Insurance and Assignment:** In further consideration of the medical care and treatment under the materials furnished by Danville Polyclinic, the Patient/Responsible Party hereby assign(s) to it my/our rights to payment from any insurance company(ies) or plan(s). The Patient/Responsible Party authorizes and directs any and all insurance company(ies) or plan(s) to make payment directly to Danville Polyclinic for all charges due and payable for the medical care and treatment, services, and materials rendered to the Patient/Responsible Party. The Patient/Responsible Party is responsible for any and all charges not covered by insurance. The Patient/Responsible Party authorizes Danville Polyclinic to release medical records and other information concerning the medical care and treatment rendered to all insurance companies or plans or their servicing agent/administrators providing coverage in order to facilitate the billing, collection, and payment of claims. The Patient/Responsible Party understands and acknowledges that Danville Polyclinic does not accept the responsibility for assuring payment of insurance benefits or negotiating a settlement of a disputed claim.

**Medicare Authorization:** Patient/Responsible Party, to the extent covered by Medicare, agrees and acknowledges that the payment of any Medicare benefits for medical care and treatment, services, or materials furnished by Danville Polyclinic, may be made directly to Danville Polyclinic. Patient/Responsible Party hereby authorizes any holder of medical information or other information about me to be released directly to the Health Care Financing Administration (HCFA) and its agents as necessary to determine and pay Medicare benefits for the medical care and treatment rendered. In addition, Patient/Responsible Party hereby authorizes Danville Polyclinic to release any information and records necessary to determine and receive payment of MediGap benefits to my supplemental insurance carrier, if any, and further assign(s) the payment of those benefits directly to Danville Polyclinic.

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**Due Date:** Payment in full is required at time of service, unless a separate payment arrangement has been made between the Patient/Responsible Party and Danville Polyclinic. Payment may be made in the form of cash, check, or credit card. All accounts are due in full 30 days from the first billing date. Other methods of payment must be arranged with Danville Polyclinic's Business Office.

**Minor Patients:** Minor patients MUST be accompanied by a parent/guardian, who presents to Danville Polyclinic a written authorization by the parent or guardian consenting to such medical care and treatment.

**Delinquent Accounts:** If more than one (1) person signs this Agreement, their liability shall be joint and several. If payment is not made when due, Danville Polyclinic may at any time thereafter, without notice or demand, determine that the entire unpaid balance of the account is immediately due and payable. In the event that Danville Polyclinic determines that it is necessary to engage the services of a collection agency and/or attorney to obtain payment of unpaid balances, the Patient/Responsible Party shall pay all costs of collection, reasonable attorney's fees and expenses incurred by Danville Polyclinic to collect the amount owed, together with interest as provided by law. Patient/Responsible Party agrees and acknowledges that the amount set forth on Danville Polyclinic's statements for medical care and treatment rendered shall be considered an account stated. This Agreement shall be construed in accordance with the laws of the State of Illinois. Patients/Responsible Parties who have filed prior bankruptcies will be required to pay for further services at the time of such service(s). Danville Polyclinic has the right to change the terms of the Payment Agreement and Authorization by sending the Patient/Responsible Party written notice of any such change. Danville Polyclinic also has the right to cancel this Agreement as it relates to the provision of future services.

***I have read the Payment Agreement and Authorization and understand and agree to all the terms stated in it. I understand that I am responsible to Danville Polyclinic Ltd. for the payment of all medical care and treatment and such other services as may be rendered by it, except as otherwise stated herein.***

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Signature of Patient/Responsible Party

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Date