

REGISTRATION FORM

P. Anthony Chapdelaine, Jr., MD, MSPH – Founder and Medical Director
General and Alternative Medicine
229 Ward Circle Suite B-12
Brentwood, TN 37027 USA

Patient Information

Date _____
Patient _____
Phone: *(Patient or Parent/Guardian)*
(Home) _____ (Work) _____ (Cell) _____
Address _____

Best time and place to reach you _____

Sex M F Age _____ Birthdate _____

Emergency contact:

Name _____
Relationship _____ Phone _____

Patient Social Security # _____

Patient: Single Married Widowed Separated Divorced

Email address *(of patient or parent)* _____

Occupation *(if child put "none")* _____

Patient's Employer _____

Work Address _____

Work Phone _____

Insurance

Who is responsible for account? Patient Spouse Parent Other

Relationship to Patient _____

Insurance Company _____

Do you have any riders or exclusions with your Insurance Company? Yes No

Please give copy of this Insurance Card and Driver's License to Receptionist

Complete the following info for the Parent or Person responsible for charges if different than the patient:

Name _____ Birthdate _____

Social Security # _____ Occupation _____ Employer _____

Address of responsible party if different than the patient:

Whom may we thank for referring you?

Is Patient covered by additional insurance? Yes No If Yes, give copy of card to Receptionist.

**** IMPORTANT INFORMATION ****
Please read and sign after reading

We are interested in your health, and want you to have the best healing experience possible. We must also bill and collect insurance on your behalf. Remember that insurance is an agreement between you and your insurance company. You are still responsible for payment of clinic services when your insurance does not pay for a visit. Sometimes insurance requires that you pay a particular amount (called a deductible) during the year, and will not pay for your office visits (and sometimes lab work) until you've paid that deductible. We will do everything we can to check for you on whether you have a copay (small amount you must pay for each visit) or deductible, although you should be aware that sometimes the insurance company representative gives incorrect information. It is always best to check with your insurance company if you are not sure about your copay and deductible.

In-Network

We are **in-network** for the following plans at present. Others will be added in the future:

Blue-Cross/Blue-Shield PPO
Cigna
United Health Care
Medicare
AETNA
Humana
PHCS
Beech Street
Great West
GEHA
Mailhandler

At the time of your first office visit you will pay any copay.

If your deductible has not been met **at the time of your first office visit, you will pay \$150** and we will bill your insurance company. For follow up visits, you will pay \$125 at the time of visit until your deductible has been met.

CLINIC PAYMENT REQUIREMENTS (if not in network or have not met deductible):

- First Visit \$180
- Follow up Visits \$150
- Brief Visit (less than 15 minutes) \$ 65

Out-of-Network

We are **out-of-network** for all other insurance companies. We will file your claim on your behalf. Depending on your deductible - none, part, or most of - the office visit charge will be paid by your insurance company. **At the time of your first office visit you will pay \$150.** After your insurance company processes your claim, we will reimburse to you any payment that is due after deductibles, copays and co-insurance amounts have been applied by your insurance. For follow up visits you will pay \$125 at each visit, and we will reimburse to you any payment due.

Cash

For **cash** patients, payment is due **at each office visit.** The first visit is \$150. Follow up visits are \$125.

RECORDS:

You may have a copy of your record for third parties by signing an authorization release form, available from the clinic. We do not disclose your medical record to others without this signed form on file unless the law compels us or authorizes us to do so.

APPOINTMENTS:

Please be aware that we require 24 hours notice if you want to change or cancel your appointment. A charge of \$25 will be billed to you for a missed appointment or if we receive less than 24 hours notice. (Unusual circumstances will be required to avoid this fee for missed appointments.)

STAFF CONSULTS:

You may call the medical assistant staff if you have questions about how to complete a lab test, prescriptions, or similar questions after your doctor appointment. If the staff cannot answer your question immediately, he/she will answer your question by the end of the clinic day after consulting, if necessary, with Dr. Chapdelaine. Otherwise the staff may request that you make another appointment with Dr. Chapdelaine. You may also email the staff or Dr. Chapdelaine. For any non-routine email, or email that requires more than three minutes to answer, or that requires further research, you will be sent an email response giving you the option of paying \$20 for Dr. Chapdelaine's time (additional fees will be charged for research requiring more than 15 minutes) or making an appointment for a doctor visit.

ASSIGNMENT AND RELEASE:

I, the undersigned, certify that I (or my dependent) have insurance coverage as described above and assign directly to Dr. Chapdelaine all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits and for treatment. I authorize the use of this signature on all insurance submissions. I have received a copy of the office's policy, procedures and privacy notice. I have read and understand the above statements concerning Clinic Payment Requirements, Records, Appointments and Staff Consults.

Patient or Responsible Party Signature _____

Relationship _____ **Date** _____