FRANKLIN-WILLIAMSON BI-COUNTY HEALTH DEPARTMENT

Patient Registration Form

Patient Name: _____

Consent to Call: Yes No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Email Address_____

Responsible Party for Patient: _____

OR

Check here if same as patient. ☐

Name of insured (who holds insurance on patient): _____

Relationship to Patient: _____ Date of Birth of insured: _____

Address: _____

City, State, Zip:_____ Phone: _____

Primary Medical Insurance – **please provide card** Secondary Medical Insurance – **please provide card**

Insurance Company Name	Insurance Company Name

Financial Responsibility: I understand that I am financially responsible for all charges for services rendered by Franklin-Williamson Bi-County Health Department/Vaxcare. I understand all co-pays and deductibles due are my responsibility. I further understand that if my insurance company has not paid within 90 days, I am responsible for the full amount due to Franklin-Williamson Bi-County Health Department/Vaxcare. If it becomes necessary for the account to be transferred to a collection agency for collection, I agree to pay all costs of collection including attorney fees.

INSURANCE WAIVER OF LIABILITY STATEMENT- I have been notified that my insurer may deny payment for today's services. If the insurer denies payment, I agree to be personally and fully responsible for payment.

By signing below, I agree that I have read this form or had the form read to me, that I was given an opportunity to ask questions, that all questions were answered to my satisfaction and that I understand and accept its terms and conditions.

Date: _____

Signature of Patient or Parent/Legal Guardian: _____

Relationship to Patient: _____

IMM002