



5030 S Mill Ave, Ste D-12 Tempe, AZ 85282
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PATIENT REGISTRATION FORM

PLEASE PRINT

Name: Last First M.I Maiden Name Date of Birth:

Address: City: State: Zip: SSN:

Home Phone: Cell Phone: Alt Phone:

Preferred Contact Number: Home Cell Email:

Race: Gender: Primary Language: Student: Full Time Part Time Veteran

Check Appropriate Box(es): Minor Single Married Widowed Separated Divorced

FINANCIAL POLICIES

Patient Insurance Responsibility: I understand that as a patient, I am responsible for fully understanding my health insurance policy, including: co-pay, deductible, benefits, and co-insurance related costs.

INITIALS

Forms: I understand there will be an additional \$50 charge for forms deemed appropriate (FMLA, Disability, etc.) that need to be filled out by a Provider.

INITIALS

No-Show/Late Cancellation Fee: I understand that I will be charged a No-Show/Late Cancellation Fee of \$25 for any missed appointments or cancellations within less than 24 hours of the scheduled appointment.

INITIALS

Non-Sufficient Funds: I understand there will be a \$25 charge for any check returned due to non-sufficient funds.

INITIALS

Collection Policy: I understand that I may be turned over to collections for further processing if a payment has not been made on my account within 90 days. NO ADDITIONAL APPOINTMENTS WILL BE MADE ON DELINQUENT ACCOUNTS UNTIL THEY ARE CURRENT.

INITIALS

Specimen Handling: Any specimens collected in-house will be sent to a contracted lab based on the health insurance provided by you at time of service. Specimens may be split and sent to different facilities as needed.

INITIALS

RESPONSIBLE PARTY SIGNATURE: DATE:

If not the patient, please state your relationship to the patient or disclose your authority to act on behalf of the patient: