

Registration

(Please Print)

SUPERIOR MEDICAL CARE, INC
5334 Meadow Lane Ct., Sheffield Village, Ohio 44035
(440) 934-5454

Date _____

Patient Name(Last, First, Middle) _____

Responsible Party (IF MINOR) _____ Responsible SS# _____

Street Address _____ City _____ ST _____ Zip _____

Home Phone _____ Cell Phone(alternate number) _____

Age _____ Birthdate _____ Social Security# _____ Marital Status S M W D

Patient Employed by _____ Work Phone _____

Spouse Name _____ Birthdate _____ Social Security# _____

Business Name _____ Work Phone _____

*Do you have Insurance coverage? Yes No IF YES, Please supply all insurance cards with this registration.

*In case of emergency, who should we notify? (Please list two)

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Which Pharmacy do you prefer? _____ City _____ Phone _____

I authorize the release of any medical or other information necessary to process claims. I authorize payment of medical benefits to the physician or practice. It is my responsibility to obtain any referrals or prior authorizations required by my insurance plan. I agree that I will be responsible to pay for any portion of the charges not covered by my insurance. If I fail to pay the out standing balance within thirty (30) days of the due date, I understand that my obligation may be referred to a third-party collection agency. The information set forth above is true to the best of my knowledge and I acknowledge that I have read, understand, and agree to all terms set forth above.

Signature(Insured/Guardian) _____ Date _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Superior Medical Care for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determined of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____ Date _____

TURN OVER ⇒

Policy for missed appointments

Should you need to cancel an appointment a twenty-four hour notice is required. Cancellations can be left on the voicemail. If a patient misses one appointment without canceling prior to appointment time, the patient will be notified by phone of the missed appointment. If a patient misses two appointments without notice, the patient will be charged \$65.00 for their missed visit, which is not billable to insurance plan. If there are three missed appointments without prior cancellation the patient will be dismissed from the practice.

I have read and understood the above policy. I undersign that it is my responsibility as a patient to adhere to this policy. This policy goes in effect the date signed below.

Signature _____ Date _____

Privacy Practices Acknowledgement

I have received the Notices of Privacy Practices and I have been provided an opportunity to review it.

Signature _____ Date _____