☐ **Methodist Richardson Breast Surgeons**
403 W. Campbell Rd., Ste. 102
Richardson, TX 75080

☐ **Methodist Richardson Family Medical Group**
399 W. Campbell Rd., Ste. 101
Richardson, TX 75080

☐ **Lakewood Hills Internal Medicine**
399 W. Campbell Rd., Ste. 102
Richardson, TX 75080

☐ **Methodist Richardson Hematology Oncology Associates**
2805 E. President George Bush Turnpike
Richardson, TX 75082

Methodist
RICHARDSON PHYSICIAN ALLIANCE

☐ **Methodist Richardson Health Center**
820 W. Arapaho Road, Ste. 200
Richardson, TX 75080

☐ **Methodist Richardson Medical Group**
2821 E. President George Bush Turnpike, Ste. 103
Richardson, TX 75082

☐ **Methodist Breckinridge Family Medical Group**
2821 E. President George Bush Turnpike, Ste. 404
Richardson, TX 75082

☐ **Methodist First Aid Family Care**
613 S. Highway 78, Ste. 200
Wylie, TX 75098

☐ **Methodist Richardson Family and Pediatric Associates**
2821 E. President George Bush Hwy, Ste. 501
Richardson, TX 75082

Patient Registration Information

Name: ____
First MI Last

Home Phone: (______)______________ Work: (______)______________ Cell: (______)______________

Address: ____
Street Apt. City State Zip

DOB.:_____ /_____ /_____ Age:_______ Sex:_______ Social Security #:______________________

Driver's License #:______________________ Reason for Visit:______________________

Emergency Contact: ______________________ Relationship:__________ Phone:__________

Referred by: ______________________ Primary Physician: ______________________
Name of Physician / Individual

Are you employed? ☐ Yes ☐ No ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Retired

If yes, employer: ______________________ Occupation: ______________________

Are you a student? ☐ Yes ☐ No ☐ Full-Time ☐ Part-Time

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Is the patient: ☐ a minor child* ☐ an adult dependent*

* If you checked either, please see the receptionist for additional information.

Primary Insurance Information

Please present your card at each visit. Deductible amount:__________ Co-pay amount:__________ PCP:__________

____
Insurance Company Name Claims Mailing Address City State Zip

____
Telephone Contact Person Group # Policy #

____
Primary Insured Insured's DOB Insured's SS # Relationship to Patient

Employer:______________________________

Secondary Insurance Information

Please present your card at each visit. Deductible amount:__________ Co-pay amount:__________ PCP:__________

____
Insurance Company Name Claims Mailing Address City State Zip

____
Telephone Contact Person Group # Policy #

____
Primary Insured Insured's DOB Insured's SS # Relationship to Patient

Employer:______________________________

Accident Information

Notice: This office may not treat worker's compensation illness/injuries or file worker's compensation claims. Please verify with the office staff.

Is this illness/injury the result of an accident? ☐ Yes ☐ No

Where did it occur? ☐ Work ☐ Auto ☐ Other Date of accident: ______________________

Have you reported the illness/injury to your employer? ☐ Yes ☐ No

Patient Initials__________

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Assignment of Benefits/Release of Information/Notice of Privacy Practices/Appointment of Authorized Representative

****Please read and initial each paragraph****

_______ **Methodist Richardson Physician Alliance** and associated physicians are committed to securing the privacy of your health information. We are supplying you with a copy of our Notice of Privacy Practices. You are not required to read this notice. By initialing, you are acknowledging receipt of this notice.

_______ I request that payment of authorized Medicare and other insurance benefits be made on my behalf to **Methodist Richardson Physician Alliance** for any services furnished to me by any healthcare providers associated with that group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or insurance company any information needed to determine these benefits or the benefits payable for related services.

_______ I appoint **Methodist Richardson Physician Alliance** to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

_______ Unless I request to the contrary, in writing, I will receive appointment reminders on my home telephone answering system and/or appointment reminder cards sent by mail, whichever is the policy of the practice.

Patient Financial Responsibility Statement

In order to maintain our fees at the lowest possible level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward that end. We encourage you to discuss it with us and ask questions.

We understand that your health coverage is provided through____
(Insurance Company)

- If you have out-of-network benefits, we will happily file claims on your behalf.
- You must pay any co-payment and applicable deductible amounts at the time of service unless other arrangements have been made with our office.
- The remainder of your bill will be sent to your health plan for direct payment to our office.
- If your insurance carrier has not paid our claim within 45 days, we will expect payment from you.
- If, by mistake, your health plan remits payment to you, please send it to us along with all paperwork sent to you at the time.
- You will remain responsible for amounts and any services that are not covered by your insurance plan.
- Your health plan may refuse payment of a claim for some of the following reasons:
    1) This is a pre-existing illness that is not covered by your plan
    2) You have not met your full calendar year deductible
    3) The type of medical service required is not covered by your plan
    4) The health plan was not in effect at the time of service
    5) You have other insurance which must be filed first

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as the patient to pay the denied amounts in full.

Our primary mission is to provide you with quality, cost effective, medical care. Together we are trying to adapt to the changing way that health care is financed and delivered. Again, we value you as a patient and our first priority is to provide you with the best possible care. With this housekeeping chore complete, we are pleased to serve you.

Sincerely,
Methodist Richardson Physician Alliance

I have completed this form with accurate information. I have read and understand my obligations and responsibilities. I acknowledge that I am fully responsible for supplying correct insurance information, billing information, and payment of any services not covered or approved by my insurance carrier.

____ _______________________
Signature of Patient or Authorized Representative Date

Consent to Treatment

I hereby give my consent for medical treatment by the physicians of Methodist Richardson Physician Alliance, to myself or dependent.

____ _______________________
Patient/Parent or Guardian Signature Date