Greater Huntsville Family Practice / Dr. Bryan D. Evans

Confidential Registration Information

___ New Patient ___ Existing Patient ____ Returning Patient ____ Updated Information

PLEASE FILL OUT FORM COMPLETLEY AND PRINT CLEARLY

DATE _____

Phone #_____

Cell # _____

Patients Name:_____

First MI Last

Mailing Address:_____

City:_____ State:_____ ZIP:_____

SSN:_____-_____-_____ Gender: Male____ or Female_____

Date of birth:_____/_____/_____

Status: Married_____ Divorced_____ Widowed_____ Single_____ Separated_____

Enrolled in School_____

Occupation:_____ Employer:_____

Business #: _____

DO YOU HAVE MEDICAL INSURANCE? YES____ or NO_____

Insurance Information:

Name of Insured:_____ Name Of Ins:_____

Date of birth _____/_____/_____ SSN:_____-___-_____

Insurance Contract #:_____

Insurance Group #: _____ Your Co Pay Amount $_____

Your Yearly Deductible Amount: $_____

Have you met your yearly deductible? _____

DO YOU HAVE SECOUNDARY INSURANCE? (We can only bill up to 2 Insurances)

Secondary Insurance Name:_____

Name of Insured:_____

Insurance Contract #:_____

Insurance Group #: _____

PLEASE BE AWARE ALL COPAYMENTS ARE DUE PAYABLE AT TIME OF SERVICE PRIOR TO SEENING THE DOCTOR.

REQUIRED BY HIPPA: WE WILL NOT RELEASE ANY INFORMATION UNLESS YOU AUTHORIZE SOMEONE TO RECEIVE INFORMATION ON YOUR BEHALF:

Person Authorized to receive Information:_____ Relationship_____

EMERGENCY CONTACT PERSON _____ **Phone #**_____

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependants. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for the services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and /or dependants, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I _____hereby authorize my insurance co_____

To pay and herby assign directly to DR. BRYAN EVANS / GREATER HUNTSVILLE FAMILY PRACTICE all benefits, if any, Otherwise payable to me for his/her services as described on the attached forms. I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to DR. BRYAN EVANS / GREATER HUNTSVILLE FAMILY PRACTICE will be credited to my account, in accordance with the above said assignment.

SIGNATURE _____ DATE _____

Bryan D. Evans M.D.

CO PAYMENTS: All Co pays are due at time of service before seeing the doctor. We have had to bill co pays and this has become a cost for us to do so and accounts have pilled up with co payments. If prior arrangements have been made with Debbie Overall the Insurance Manager and co payments have to be billed we will have to charge a $3.50 fee for billing of these co payments. **INITIAL**_____

APPOINTMENTS: Patients are seen by appointments only. Appointments are scheduled from 9:00am to 11:00 am and 1:30pm to 3:30pm closed for lunch from 12:00pm to 1:30pm Monday, Tuesday, Thursday and Friday. We will only be able to schedule routine physicals one in the mornings and one in the afternoons in which may push your physical out. When patients call for appointments, we make every effort to see that patient as soon as possible. However, when our schedule is full, missed appointments and appointments canceled at the last minute often deprives other patients from the opportunity to be seen that day. For this reason, you may be billed for scheduled office visits that were not canceled at least 24 hours in advanced. We understand emergencies may arise and we will work with you. Physicals missed without prior cancellation and NO Show, NO Call we will bill $60.00. Regular office visits without prior cancellation and No Show, No Call we will bill $35.00. **INITIAL**_____

PRESCRIPTIONS / RX CALL IN'S: Patients that have been seen in the office and did not get regular prescribed prescriptions on the day of the office visit, We will have to charge a refill fee of $25.00 billed to the patient. When you come in to see the doctor make sure you bring a list of all your current prescriptions you are currently taken. If you are scheduled to come in for an office visit and miss your appointment we will do our best to reschedule your appointment and not charge for your refills needed. We must have you on the schedule to come in before your next refills are due. **We have a 24 hour refill policy that we will enforce unless it is prescriptions needed for infections and colds. Controlled prescriptions** we will have to see the patient in our office every 2 months for a follow up with Dr. Evans. Patients that fail to follow up may result in delay and or prescriptions not be given until patient has been seen by the doctor. **INITIAL**_____

INSURANCE: Patients who carry Health Insurance should remember professional services are rendered and charged to the patient and not the insurance company. Dr. Evans is a provider for the following Insurance Companies: Aetna, Blue Cross Blue Shield of Alabama, Federal Blue Cross Blue Shield, United Health Care, Health Network, Humana, Prime Health, Medicare, Med Net, PHCS, Premier, PHA, First Community Health and MHBP,Tri Care Patients insured by these companies are responsible for co-payments at the time of service rendered. Patients not covered by these Insurance Companies are responsible for payment in full at the time of services rendered unless prior arrangements have been made. Insurance Billing and Collection is done in office and by our billing company, we soon hope to bring all billing and collections in office only. **INITIAL**_____

GUARANTEE OF ACCOUNTS: I/We, the undersigned, hereby agree to pay all amounts and charges hereafter incurred by me or my family for services furnished by this office. Failure to make payment when requested is basis for legal action and I/We agree to pay all cost of collection including a reasonable fee and hereby waive my/our right of exemption under the law of the State Of Alabama and any other state. **INITIAL**_____

INSURANCE AUTHORIZATION: I request that payment of authorized benefits be made either to me or on behalf to Bryan D. Evans M.D. for any services furnished by this office. Further, I authorize the release of any and all medical information necessary to process insurance claims. **INITIAL** _____

CONSENT AGREEMENT: If a patient is under the age of (18) I _____ as this patients parent/guardian, agree to give my overall consent to their treatment by the physician Bryan D. Evans M.D. **INITIAL**_____

_____ _____

Print Patient's Name **Today's Date**

_____ _____

Signature of Patient **Signature of Responsible Party**