Primary Care Associates of Hagerstown, LLC
Patient Registration and Billing Agreement

Date: ____________________

PATIENT INFORMATION

Patient Name: First ______________________________ MI ______ Last ______________________________ SS# ______________________

DOB: ________________ Sex: ☐ M ☐ F ☐ Other ____________ Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Life Partner

Parent / Legal Guardian name if patient a minor Name: ____ DOB: ______________________

Race: ☐White ☐Black/African American ☐Asian ☐American Indian/Alaska Native ☐Native Hawaiian/Pacific Islander ☐Declined

Ethnicity: ☐Not Hispanic/Latino ☐Hispanic/Latino ☐Declined

Preferred Language: ☐English ☐Spanish ☐Other ________________________________

Address: ____ City ______________ State __________ Zip ____________

Phone: Home ____________________________ Cell ____________________________ Work ________________________________

Email: ____

Best Contact Method: ☐Home ☐Cell ☐Work ☐Email ☐Mail

Employment Status: ☐Full-Time ☐Part-Time ☐Unemployed ☐Student ☐Disabled ☐Retired Employer / School: ____________________________

FINANCIALLY RESPONSIBLE PARTY

☐ **Same as patient** (If different please complete this section)

Name: First____ MI ________ Last ____

Relationship to patient: ☐Spouse ☐Parent ☐Guardian ☐Other ____

Address: ____ City ______________ State __________ Zip ____________

Phone: Home ____________________________ Cell ____________________________ Work ________________________________

Email: ____

Employer: ____

EMERGENCY CONTACT

Name: ____ Relationship to Patient: ________________________________

Phone: Home ____________________________ Cell ____________________________ Work ________________________________

I consent to treatment necessary for the care of the above-named patient.
I authorize the release of all medical records to the referring physician and to my insurance company, if applicable.
I allow fax transmittal of my medical records, if necessary.
I allow emailed transmittal of my medical records, if necessary.
I acknowledge full financial responsibility for services rendered and I agree to payment for services if insurance has not paid within 120 days.
I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that insurance payments be made directly to Primary Care Associates of Hagerstown, should they elect to receive such payment.

This agreement will remain in effect while the patient is under the medical treatment of this office.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

Signature: ____ Date: ____________________________________