Account No. ______________________

QUEEN CITY PHYSICIANS PATIENT REGISTRATION FORM

Patient Name ______________________________

Name of person responsible for bill (if not patient) ______________________________

Billing Address ______________________________ Street ______________ City __________ State __________ Zipcode

Billing Phone ______________

Home Address ______________________________ Street ______________ City __________ State __________ Zipcode
IF NOT SAME AS BILLING ADDRESS

Home Phone ______________ Cell Phone ______________ Email ______________

Employer ______________ Occupation ______________ Work Phone ______________

INSURANCE INFORMATION ☐ CHANGED ☐ SAME

1st Insurance Coverage ______________________ Office Co-Pay ______________

Subscriber Name ______________________________

Subscriber Employer ______________________________

Insurance ID Number ______________________ Effective Dates ______________

Gender __________ Birthdate ______________ SSN ______________

Relationship of Patient to Policyholder ☐ Self ☐ Spouse ☐ Dependent

2nd Insurance Coverage ______________________ Office Co-Pay ______________

Subscriber Name ______________________________

Subscriber Employer ______________________________

Insurance ID Number ______________________ Effective Dates ______________

Gender __________ Birthdate ______________ SSN ______________

Relationship of Patient to Policyholder ☐ Self ☐ Spouse ☐ Dependent

Sign on Page 2 **Continue on Page 2** **Sign on Page 2**

IN CASE OF EMERGENCY NOTIFY (Someone not in Patient's Household

Contact Name ______________________ Relationship to Patient ______________________

Contact Address ______________________ ____________ ________ ________
Street City State Zipcode

Home Phone ______________ Work Phone ______________

How did you hear about Queen City Physicians? ☐ Family/Friend ☐ Internet ☐ Newspaper
☐ Insurance Co Provider Manual ☐ TV/ Radio ☐ Word of Mouth ☐ Other

AUTHORIZATION

By signature below I state the above information to be true and correct. I hereby authorize the physicians of Queen City Physicians, to treat the patient named above for medical and surgical procedures on scheduled or emergency basis at any location and to submit a claim to my insurance carrier(s) or its intermediaries for all services rendered by the physician or their agents and hereby direct my insurance carrier(s) or its intermediaries to issue payment DIRECTLY to QUEEN CITY PHYSICIANS on behalf of such rendered services. I understand that I am financially responsible to this office for any balance not covered by my insurance carrier. **A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.**

Signature ______________________ Date ______________

Acknowledgment of Receipt of Notice of Privacy Practices: The undersigned Patient, Parent or Legal Guardian of the Patient, acknowledges that he or she personally received a copy of the Queen City Physicians Notice of Privacy Policies on the date indicated below.

Signature ______________________ Date ______________

Acknowledgment of Receipt of QCP Financial Policy: I have received a copy of the Queen City Physicians Financial Policy and understand that I am ultimately responsible any charges incurred.

Signature ______________________ Date ______________