**Office of Lamont Cardon, MD**

**Patient Registration Information**

**Please PRINT & Complete ALL Sections Below.**

Full Name: ________________________________________ Date of Birth: ________________________ Sex: ____________

Home Address: ______________________________ Apt. #: ______ City: _________________ State: _______ Zip: _____________

Home Phone: ( ) ____________________________________ Day Time/Cell Phone: ( ) _________________________

Driver's License #: ________________________________________ SSN#: _______________________________________________

Email Address: ________________________________________________________________________________________

Employer's Name & Address: ____________________________________________Work phone ( ) ___________________

Marital Status: _________________________________

Race/Ethnicity: __________________________________ Preferred Language:_______________________________________

Emergency Contact: ______________________________ Relation: ____________________ Phone: ( ) ______________

PATIENT'S INSURANCE INFORMATION. **Please present insurance cards to Receptionist**.

Subscriber Name: ____________________________________________ DOB: ________________________________________

(If applicable) Name of parent or Legal guardian: ______________________________________________________________

**Financial Policy**

Your insurance coverage is a contract between you and your insurance company. We will inform you if we are a party to your insurance contract, and will handle your claims according to our agreement with the insurance company. **We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, etc.**

Verification of insurance coverage is your responsibility. If your insurance plan requires pre-authorization, it is the responsibility of you and your primary care provider to obtain pre-authorization for you to be seen by one of our providers. Otherwise, the charges incurred may become an out-of-pocket expense to you. When we are contracted with your insurance company we will bill them first as a courtesy to you. After explanation of benefit (EOB) and/or payment is received, the balance or remainder of balance is your responsibility. Final payment should be submitted in a timely manner (within 30 days from receipt of insurance payment/EOB or Date of Service). After 30 days, a late charge of 1.5% of the unpaid balance will incur each month until the balance is paid off.

**Form & Cancellation and/or Missed Appointment Fees:**

We require a 24 hour notice of appointment cancellations, otherwise a $ 50.00 late cancellation and / or missed appointment fee will be billed to you. Our fee schedule for ancillary & supplemental insurance forms is as follows: 1-2 pages $ 20.00; 3-5 pages $ 40.00; 6-10 pages $ 60.00; forms in excess of 10 pages $ 12.00 per additional page. California State Disability (EDD) forms $20.00; DMV Forms for disabled placard $ 20.00.

**Splints, AquaCast Liner and/or Durable Medical Equipment**

If we provide a splint, AquaCast liner or other item of Durable Medical Equipment; we will require payment for the item at the time of your visit. We will give you a receipt if requested so that you may request reimbursement from your insurance company. We will not bill your insurance for the item (very few insurances pay for Durable Medical Equipment).

**Authorization to Release Benefits, Payments and/or Medical Records**

I request that payment of allowed and/or authorized benefits be made on my behalf to Lamont Cardon, MD for any services furnished by him or Broheen Elias, PA-C. I also authorize Lamont Cardon, MD to release any information from my medical record to the insurance company for payment of claim submitted.

**Having read and understood this Financial Policy, I submit the following signature.**

Signature: ____________________________________________________ Date: ______________________________

If signing on behalf of patient- state name & relation to patient: ________________________________________________