Ravalli Family Medicine
Patient Registration/Financial Agreement (Adult)

Thank you for taking the time to complete this form. This information is necessary for the preparation of your clinical records. You are responsible for all charges billed. Our credit office personal will be happy to discuss a payment schedule that is most convenient for you.

PLEASE PRINT AND COMPLETE ENTIRE FORM.
WE ARE UNABLE TO BILL INSURANCE WITHOUT BIRTHDATES AND SS#.

Patient information:

Patient Name: _____
First Middle Last

Mailing address: _____ City: _____ Zip_____

Home address: _____ City: _____ Zip _____

Phone numbers: Home:_____ Work:_____ Cell:_____

If you cannot reach me at home it is OK to try me at: ☐ Work ☐ Cell ☐ It is not OK to call other numbers

Email address: _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Birthdate: _____ SS#: _____ ☐ Male ☐ Female

Employer: _____ Address: _____

Occupation: _____

Spouse Name: _____ Birthdate: _____ Contact #:_____

Emergency Contact (other than spouse):

Name: _____ Relationship: _____

Address: _____ Phone: _____

Insurance:

☐ check if you are primary on insurance

Primary insured's name: _____

Birthdate: _____ SS#: _____
WE CANNOT BILL INSURANCE WITHOUT THIS INFORMATION

I authorize the release of any medical information which may be requested to process claims for payment of medical services through my insurance carrier, prepaid medical plan, or government agency. I authorize payments to be made to the clinic or providers.

If no insurance: ☐ Cash ☐ Credit/Debit card

I assume liability for all non-covered charges and deductibles. By signing this form I acknowledge that I have received a copy of the Notice of Privacy Practices and payment policy of Ravalli Family Medicine.

Signature of Responsible Person Date Relationship