LEXINGTON CLINIC
Patient Registration Form

ACCOUNT/MRN: _____ **Date**: _____

PATIENT DEMOGRAPHIC INFORMATION

Name: _____ **Address:** _____Apt. / Suite: _____

City: _____ **State:** _____ **Zip:** _____**Country Code:** _____

Home Phone: (_____)_____**Cell Phone**: ( ) _____ **Email Address**: _____

Birth Date: _____ **Sex:** ____Male ____ Female **SS#**: _____

Marital Status: ___Single ___ Married ___ Divorced ___ Widowed **Primary Care Physician:** _____

Emergency Contact Name: _____ **Relationship**: _____ **Phone:** (_____)_____

Race: ___Caucasian ___African-American ___Hispanic ___ Asian/ Pacific Islander ___American Indian/Alaskan Native

____Other **Ethnicity**: ___ Hispanic ___ Non Hispanic **Primary Language**: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____

Work Phone: __(_____) _____

RESPONSIBLE PARTY BILLING INFORMATION

Name: _____ Address: _____

Apt. / Suite: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____

INSURANCE INFORMATION **Primary Insurance**

Insurance Name: _____ I.D. #: _____

Group #: _____ Effective Date: _____ Address: _____

City/State/Zip: _____ Phone: ___(____)_____

Subscriber Name: _____ Relationship to Patient: _____

Address: _____ City/State/Zip: _____

Birth Date: _____ Sex: _____ Male _____ Female Soc. Sec. #: _____

Employer Name: _____

Address: _____ City/State/Zip: _____

Secondary Insurance

Insurance Name: _____ I.D. #: _____

Group #: _____ Effective Date: _____ Address: _____

City/State/Zip: _____ Phone: ___(____)_____

Subscriber Name: _____ Relationship to Patient: _____

Address: _____ City/State/Zip: _____

Birth Date: _____ Sex: _ _____Male _____ Female Soc. Sec. #: _____

Employer Name: _____

Address: _____ City/State/Zip: _____

LEXINGTON CLINIC
Patient Registration Form

Auto Accident

Date of Accident: _____

Liability? _____Yes _____No

Claim number: _____

Insurance: _____

Address: _____

_____

Phone: ( ) _____

Workman's Compensation Injury

Injured on job? ____ Yes ____ No Date of injury: _____

Authorized By: _____

Claim Number: _____

Billing Address: _____

_____

_____

Phone: ( ) _____

AUTHORIZATION FOR CONSENT FOR TREATMENT AND ASSIGNMENT OF PHYSICIAN BENEFITS

CONSENT FOR TREATMENT

I hereby consent to examination and treatment by Lexington Clinic, PSC, including diagnostic and/or therapeutic procedures ordered by the physician.

As a part of the medical or surgical procedures or tests authorized by my doctor or doctors and if so ordered by him, her, or them, I consent to be tested for human immunodeficiency virus infection (AIDS), hepatitis, or any other blood borne infectious disease for diagnosis or other purposes directly related to medical treatment. If a health care worker is exposed to my blood or body fluids, the Lexington Clinic may, at its cost, test my blood for any infectious disease. The Lexington Clinic shall confidentially maintain to the extent provided by applicable law: a) the fact that a blood test is ordered, and b) the results of such tests.

Personal Due Balances

Any accounts not paid in full or on an approved payment plan within 30 days of their first statement are considered delinquent. The Lexington Clinic may access information available through credit reporting agencies and services for the purpose of debt collection. Delinquent accounts that remain unpaid may also be referred to an outside collection agency. The patient may be held responsible for payment of any court costs and/or attorney fees incurred by the collection agency during their collection process.

Assignment of Benefits

I authorize direct payment of benefits provided under any health care plan or medical expense policy due to me or payable on my behalf to Lexington Clinic. I further authorize release of information required by any third party payor regarding this claim. I permit a copy of this authorization to be used in place of the original. I acknowledge that any or all of the expenses not paid by my third-party payor, as defined under my plan benefit contract, are my responsibility.

Applicable to Medicare Patients: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare program or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

_____	_____	_____
DATE	Signature of Patient or Person Authorized to consent	Relationship to the Patient

_____	_____
DATE	WITNESS