Spring Grove Family Care Center

Howard H. Farrington III M.D.

2030 Thistle Hill Drive, Suite 200
Spring Grove, PA 17362

Phone 717-225-6556
Fax 717-225-0356

Patient Information
Adult Registration

Name-Last, First, Middle _____ Birthdate _____ Social Security # _____

Street Address _____ Cell Phone _____

City _____ State _____ Zip Code _____ Home Phone _____

Employer Name _____ Work Phone _____

Employer Address- Street, City, State, Zip Code _____

Marital Status _____ Name of Spouse _____ Emergency Phone _____

Previous Physician _____ Address _____

Payment Information

Responsible Party Name _____ Birthdate _____ Social Security # _____ Phone _____

Employer Name _____ Employer Address _____

Primary Insurance _____ Secondary Insurance _____

Authorization

I consent to treatment as necessary or desirable to the care of the patient, including but not restricted to whatever drugs, medicine, surgical procedures and diagnostic testing including laboratory, x-ray, or other studies that may be used by the attending physician, or qualified designate. I authorize the physician, designate, or practice to release pertinent information regarding my medical care, services, and treatment to the Centers for Medicare Services and/or my current insurance carrier and their agents for the purpose of determining the benefits payable for these and/or related services. I request that the payment of authorized Medicare and/or Insurance benefits be made on my behalf to the aforementioned provider/practice. I understand that I am responsible for all fees regardless of insurance coverage.

Signature of Patient/Responsible Party/ Power of Attorney _____ Date _____

Our Financial Policy

Thank your for choosing us as your healthcare provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of the treatment process. The following is a statement of our "Financial Policy" which we require that you read and sign prior to our rendering any service or treatment is rendered.

Payment in Full is Due At The Time Of Service Unless Prior Arrangements Are Made.

We Accept Cash, Check, Visa, Master Card Or Money Order.

Patients Who Have No Insurance And Are Paying For Their Visit In Full Will Receive A 20% Discount At Checkout.

Insurance Participation

We may accept assignment of benefits from designated insurance carriers. However, we do require that the estimated co-payments and Deductibles be paid at the time of service. The balance is your responsibility whether your insurance pays or not. We cannot bill your insurance company unless you provide current and accurate insurance information. Our office will require copies of the front and back of our insurance Cards.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract unless you are insured by a plan with which we participate and have signed an agreement. If your insurance company has not paid your account in full within 60 days, the balance due will be automatically transferred to your account. Please be aware that some, and perhaps all of the services provided to you may be considered non-covered or not reasonable and necessary under the policies of your medical insurance carrier or Medicare. In the event that your insurance coverage changes to a plan with which we do not participate, we will require assignment of benefits to our office or full payment will be due according to the payment arrangements.

Adult Patients

Adult patients are responsible to adhere to the above policy which may require full payment at time of service.

Minor Patients

The adult **Accompanying** a minor and the parents(or guardians of the minor) are responsible for full payment.

Thank you in advance for your understanding of our Financial Policy. Please let us know if you have any questions or concerns.

I have read and understand the "Financial Policy" and agree to abide with the requirements.

_____

Signature of Patient or Responsible Party Date