NP Expired Insurance Change Address Change Name Change Other _____

AURORA FAMILY PRACTICE GROUP P.C

PLEASE COMPLETE *ALL (*)* INFORMATION

***** *EXPIRES* 1 YEAR FROM DATE *LAST* SIGNED *AND ANY* TIME THERE IS *ANY CHANGE*. THIS IS AN *INSURANCE REQUIREMENT* *****

Date _____ Patient Registration / Update / Annual Please write legibly – ***Required***

PATIENT INFORMATION

Last* _____ First* _____ M.I _____ DOB* _____

Sex/Gender* _____ Preferred Name _____ Preferred Pronoun(s) _____ SSN* _____

Address* _____ Apt/Unit _____ City/State/Zip* _____ lling purposes on

E-MAIL _____ Home* _____ Cell* _____

Occupation _____ Work Ph # _____ Best Contact Method _____

Married Single Widowed Other **Local Pharmacy** _____ **Mail Order** _____

RESPONSIBLE PARTY INFORMATION Self Spouse Parent *Self*, unless resp party present to sign OR minor)

Last* _____ First* _____ M.I _____ DOB* _____

Sex/Gender* _____ Preferred Name _____ Preferred Pronoun(s) _____ SSN _____

Address _____ Apt/Unit _____ City/State/Zip _____ lling purposes or

E-MAIL _____ Home* _____ Cell* _____

Occupation _____ Best Contact Method _____

RESPONSIBLE PARTY SIGNATURE _____

Note: A signature *must* be on file to make someone other than yourself responsible for your account.

Emergency Contact* _____ Relation* _____

Home/Cell* _____ E-MAIL _____

Emergency Contact _____ Relation _____

Home/Cell _____ E-MAIL _____

PRIMARY INSURANCE **Insurance section(s) requirement**, even if we scanned your card(s)

Company* _____ Provider Ph _____

Address *(Usually PO Box)* _____ City/State/Zip _____

☐ Self Subscriber Name* _____ DOB* _____ SSN* _____ Billing urpose: only

Subscriber ID* _____ Group # _____ PCP Copay *(If any)* $ _____

SECONDARY/SUPPLEMANTAL

Company* _____ Provider Ph _____

Address *(Usually PO Box)* _____ City/State/Zip _____

☐ Self Subscriber Name* _____ DOB* _____ SSN* _____

Subscriber ID* _____ Group # _____ PCP Copay *(If any)* $ _____

Tertiary Insurance? Let front staff know!

PLEASE ***TURN*** OVER FOR SIGNATURES

Financial Agreement/Assignment of Benefits

I *understand* that I am *financially responsible* and *agree* to pay *all* of Aurora Family Practice Groups' charges and *any* related charge that are *not paid by insurance* or any third-party payer. I *authorize* payment directly to Aurora Family Practice Group for all benefit otherwise payable to me. I *understand* that *if I do not provide all* of the requested or necessary information, I *will* be responsible for *all* charges until such information is provided.

I, X_____, give my *authorization* for Aurora Family Practice Group, to bill my insurance company for *all* services rendered for the duration of my coverage with,

*_____ *_____

Name of Insurance Company Date

By signing below, I *certify* that I have read this agreement and/or that it has been fully explained to me, that I *understand* its' content and that I am the *patient*, or the person duly *authorized* to execute this agreement and *accept* its' terms.

X_____ *_____

Signature of patient or responsible party Date

Relationship *(If other than patient)* _____

Acknowledgment of Receipt of Notice of Privacy Practices

I *acknowledge* that I have received and read the Notice of Privacy Policy and Procedures and that I have had any questions regarding this notice answered to my satisfaction.

X_____ *_____

Signature of patient or responsible party Date

*_____ _____

Print Name Representative & Title

Optional –

I, _____, give my *consent* to a *detailed voicemail* message from Aurora Family Practice Group to be left via telephone, if I am unable to be reached. *(Check all that apply.)*

☐ Home ☐ Cell ☐ Work

I, _____, give my consent to the patient portal with the email I provided, to access my person and confidential labs, records, and messages.

_____

Signature

How were you referred to us? _____