DENISE W.L. HEW, M.D., LLC

PATIENT REGISTRATION FORM — Please fill out this form to register as a patient of Denise W.L. Hew, M.D. We cannot register you as a patient without this information. Please print clearly.

PATIENT INFORMATION

Name _____ Birthdate _____
Address _____ SSN _____
City _____ State _____ Zip Code _____
Ethnic background _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Occupation _____ Home phone number _____
Employer _____ Work/business number _____
Best numbers to contact you at _____ Cell/pager number _____
May we identify ourselves as your doctor's office? _____ Is it okay to leave a message? _____

INSURANCE INFORMATION

Primary insurance _____
Subscriber's name _____ Relationship _____ DOB _____
Subscriber's ID # _____ Group # _____ Cov Code _____

Secondary insurance _____
Subscriber's name _____ Relationship _____ DOB _____
Subscriber's ID # _____ Group # _____ Cov Code _____

RESPONSIBLE PARTY FOR PATIENT PAYMENTS

Name _____ Birthdate _____
Address _____ SSN _____
City _____ State _____ Zip Code _____

EMERGENCY CONTACT (S)

Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____

ADDITIONAL INFORMATION

Whom should we thank for referring you? _____
Address _____
Who is your Primary Physician? _____ Phone _____
Address _____
If the patient is a child, who may authorize treatment for this child? _____
Relationship to patient/child _____ Phone _____
Do you authorize release of your medical information to anyone besides your insurance carrier(s)? _____
If yes, whom? _____

ASSIGNMENT AND RELEASE—By signing, you agree to the following:

I hereby authorize Denise W.L. Hew, M.D., LLC, and/or its representative, to release all medical information regarding my illness; past, present, and future care; and/or injury, to my insurance carrier(s), any health care facility, and any other physician that would benefit my health care. I further authorize the release of billing information and dates of services to any collection agency or attorney retained by Denise W.L. Hew, M.D., LLC. I hereby assign all medical and/or surgical benefits, to which I am entitled, to Denise W.L. Hew, M.D., LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is as valid as the original. I understand that I am financially responsible for 1) all charges incurred, whether or not they are paid by my insurance; 2) payment of services in full if my insurance is terminated or I exceed my annual benefits; and 3) services not covered by my insurance, including telephone consultations. I agree to make minimum monthly payments on any balance exceeding $100. This office reserves the right to charge a late payment fee, a returned check fee, and/or a no show fee. Should the account be referred for collections, I agree to pay any reasonable attorney's fees, collection expenses and interest at the statutory rate on all delinquent accounts. I understand that failure to pay for services rendered will result in suspension or termination of services by Denise W.L. Hew, M.D.,LLC.

Signature of patient _____ Date _____
(or parent or guardian if patient is a minor)