Century Medical PC
Alexander M. Katz, MD
84 Highland Ave Suite 312
Salem, MA 01970
978.594.8980
978.594.8591

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____

Primary Insurance Company: _____

Secondary Insurance Company: _____

Address: _____ City: _____ State: ____ Zip: _____

Male: __ Female: __ Single: __ Married: __ Widow:__ Student: __ (Full Time: __ Part Time: __)

Best number to reach you: (___) ____-_____ 2nd Number: (___) ____-_____

Preferred Language: _____ Race: _____ Ethnic Origin: _____

Employer: _____

Emergency Contact: _____ Relationship: _____

Phone Number: (___) ____-_____

Pharmacy: _____ Location: _____

If applicable please fill out section below

Home Care Agency: _____

Nurse Phone Number: (___) ____-_____

Day Care Agency: _____

Phone Number: (___) ____-_____

RESPONSIBILITY FOR COPAYMENT: I agree to pay all applicable health plan copayments at the time of service.

PAYMENT PAST DUE: I understand that all health plan deductibles and charges for non-covered benefits are due and payable upon presentation of a billing statement from Century Medical, PC. I also understand that all invoices remaining unpaid after 30 days will incur a $10 per month late fee until the balance is satisfied.

DELINQUENT ACCOUNT: I understand that Century Medical, PC assigns delinquent accounts to Carter Business Services, Inc. In the event my account is sent to collections, I am aware that I will be asked to pay a 20% collections fee in addition to the balance due until the balance is paid. All payments made to Century Medical, PC must be made in cash or credit card only.

_____ _____

Signature of Patient (or Guarantor, if applicable) Date

_____

Please print name of patient

Financial Policies

PAYMENT is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, payment in full is expected at the time of your visit.

INSURANCE: We are participating providers with several insurance plans. We will file all of these insurance claims. In order to do this, we require all information to be completed on the Patient Registration Form. We must have this information prior to your appointment. We will request an update to your information at each visit. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you.

If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Please contact your insurance company at the customer service phone number printed on your insurance card if you have questions pertaining to coverage.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

INVOICES: If you receive an invoice from our office for a balance due, it is because that is the balance your insurance policy requires you to pay. Please contact your insurance company first if you think there is a problem. The balance on your invoice should be equal to the "Patient Responsibility" portion on your Explanation of Benefits that you receive from your insurance company plus any "non-covered services" (less any copay that was collected at the time of service). If you believe there is a discrepancy, please call us at ..... and speak to our billing staff to advise. You will continue to receive invoices and be subject to collections if you do not advise us of discrepancies.

COLLECTIONS: Invoices not paid within 30 days begins our collections process. Invoices not paid within 60 days are subject to patient dismissal and submission to Carter Business Services, Inc. and notification to your insurance plan. The following services are considered "non-covered" services:

- **Returned check:** If your check is returned to us for any reason, you will be assessed $25.00 fee. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $25 service charge to pay the balance prior to receiving services from our staff or the physician. All bad checks written to this office are subject to collections. No further checks will be accepted.
- **Missed appointment:** If you fail to notify us at least 24 hours in advance you may be charged $25.00 for an office visit; and $50.00 for a scheduled physical.
- **Collection Fee:** 20% collection fee in addition to collection account must be paid.

RESPONSIBILITY FOR PAYMENT: I acknowledge that acceptance of my insurance information is not a guarantee of payment by my health plan until the claim has been accepted and processed. I further understand that if my claim is not accepted for payment I am personally responsible for payment of medical services rendered to me.

AUTHORIZATION FOR MEDICAL INFORMATION & PAYMENT OF MEDICAL BENEFITS

1. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MEDICAL CLAIM FOR SERVICES PROVIDED BY THE PHYSICIAN.

2. I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE PHYSICIAN FOR SERVICES PROVIDED.

3. I AGREE THAT ***CENTURY MEDICAL, PC*** CAN REQUEST AND USE MY PRESCRIPTION MEDICATION HISTORY FROM OTHER HEALTHCARE PROVIDERS AND/OR PHARMACY NETWORKS FOR TREATMENT PURPOSES.

Print Full Name: _____

Signature: _____ **Date:** _____