SAUCON VALLEY MEDICAL CENTER
URGENT CARE - PRIMARY CARE

EAST PENN MEDICAL CENTER
URGENT CARE - PRIMARY CARE

Registration

Last Name: _____ First Name: _____ DOB: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Sex: (M)/(F) SSN: _____-____-_____ Marital Status: _____

Cell Phone: _____ Home Phone: _____Work Phone: _____

Email: _____ Employer Name & Address: _____

Ethnicity: (please circle) Hispanic/Latino or Non-Hispanic/non-Latino

Race: White Hawaiian/Pacific Islander African American American Indian Asian Other **(circle one)**

Primary Care Physician/Phone number: _____

Are you interested in SVMC/EPMC becoming your Primary Care Provider? *Please Circle:* Yes No

Emergency Contact/Relationship: _____ **Phone#**: _____

Pharmacy Name: _____ Location (Town): _____

How did you hear about us (circle one): Driving by Internet search Friend Other _____

Insurance Information:

Primary Insurance: _____
Policy #_____ Group#: _____
Policy Holder Name (if different from patient): _____
DOB: _____ Relationship **to patient**: _____
***Address (if different): _____**

Secondary Insurance: _____
Policy #_____ Group#: _____
Policy Holder Name (if different from patient): _____
DOB: _____ Relationship **to patient**: _____
***Address (if different): _____**

By signing below, I agree that ALL the above information given is true and accurate.

***SIGNATURE*: _____** Date*:* _____
Relationship to patient: _____

I authorize Saucon Valley Medical Center/East Penn Medical Center to obtain/have access to my medication history
***SIGNATURE*: _____** Date*:* _____

Thank you for Choosing Saucon Valley Medical Center / East Penn Medical Center as your healthcare provider. We are dedicated to providing cost effective high quality care - specializing in Primary Care and Urgent Care.

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business/billing office. Necessary forms will be completed to file for insurance carrier payments. Please be aware that not all insurance carriers consider all services rendered a covered benefit. It is important that you are aware of your insurance policy provisions and coverage.

Accurate, up to date information is the patient's responsibility; please notify our office of any changes to your insurance or personal billing information. Please bring to each appointment your current insurance card, or any other information that is required by your insurance carrier

Payments can be made by cash, check (PA residents only), money order, Visa, MasterCard or Discover Card. We do have a payment plan for patients who have financial concerns. You may contact our billing office at (610) 625-2010. Please be aware that charges for physical therapy, durable medical equipment, lab testing and some radiology services may be billed separately.

There is a $40 returned check fee for each item that is returned by your financial institution. Any accounts referred to an outside collection agency will incur a $50 collection fee per referral item.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment (EFT/checks) directly to Saucon Valley Medical Center/East Penn Medical Center for services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Saucon Valley Medical Center/East Penn Medical Center to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.
I have requested medical services from Saucon Valley Medical Center/East Penn Medical Center on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for and all charges incurred in the course of the treatment authorized.
I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party ***SIGNATURE*** ***Date Signed***

Notice of Privacy Practices Acknowledgment

Saucon Valley Medical Center
4801 Saucon Creek Road, Suite #110
Center Valley, PA 18034
T: (610) 625-9090

East Penn Medical Center
1003 Chestnut Street
Emmaus, PA 18049
T: (610) 928-1150

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Please list any person(s) that Saucon Valley Medical Center/ East Penn Medical Center can contact or speak to about your medical information. Please document their name and relationship to the patient. This includes any physician practices we may speak to.

(1)_____ (4)_____

(2)_____ (5)_____

(3)_____ (6)_____

Please write the phone numbers for which SVMC/EPMC may contact YOU and leave a brief message*

(HM)_____ (WK)_____ (CELL)_____

**I authorize my provider's office to contact me by mobile phone and email

_____ _____

Patient Name or Legal Guardian (print) **Date**

_____

Signature