



**Roy B. Parke, D.O.  
And Associates**  
1045 East Front Street  
Buchanan, MI 49107

**REGISTRATION INFORMATION**

*Welcome to our office! – Please print. Thank you!*

Name \_\_\_\_\_ Today's Date \_\_\_\_-\_\_\_\_-\_\_\_\_  
(Last) (First) (MI)

Address \_\_\_\_\_ Birthdate \_\_\_\_-\_\_\_\_-\_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Home Phone (including area code) \_\_\_\_\_ Work Phone (including area code) \_\_\_\_\_

Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_ Occupation \_\_\_\_\_

Employer Name & Address \_\_\_\_\_

Marital Status: S M W D Spouse Name (if applicable) \_\_\_\_\_  
(circle one)

Who is responsible for this account? \_\_\_\_\_

Relationship to patient: Self Spouse Parent Other \_\_\_\_\_  
(circle one)

Address \_\_\_\_\_

Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_ Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

Home Phone (including area code) \_\_\_\_\_ Work Phone (including area code) \_\_\_\_\_

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Your drugstore Name \_\_\_\_\_

Phone \_\_\_\_\_ City \_\_\_\_\_

Emergency contact outside immediate family:

Name \_\_\_\_\_ Phone \_\_\_\_\_

This office has my permission to (please check all applicable)

\_\_\_ Leave a message with my family                      \_\_\_ Leave a message at work

\_\_\_ Leave a message on my answering machine                      \_\_\_ None of above

\_\_\_ Release medical information to \_\_\_\_\_  
(i.e. to allow family to pick up med records/prescriptions)

**PLEASE RETURN ALL FORMS TO THE RECEPTIONIST WHEN YOU ARE FINISHED  
THANK YOU !**

**ADDITIONAL INFORMATION**

Has any member of your immediate family been treated here? Y N

How did you learn about us? \_\_\_\_\_

We ask that our patients have regular complete physicals. Please indicate the LAST DATE of each type of exam listed below and indicate, IN THE FUTURE, whether you will have these exams here or with another physician (give the name of the other physician).

Last physical \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ BFMC \_\_\_\_ OR Other Dr \_\_\_\_\_

Last pap \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ BFMC \_\_\_\_ OR Other Dr \_\_\_\_\_

Last mammogram \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ BFMC \_\_\_\_ OR Other Dr \_\_\_\_\_

\_\_\_ "I refuse to have any of the above services."

Signature \_\_\_\_\_ Date \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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"I HAVE READ THE STATEMENTS BELOW REGARDING PAYMENT AND CONSENT AND MY SIGNATURE BELOW CONFIRMS THAT I AGREE WITH THE TERMS."

Signature \_\_\_\_\_ Date \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

(parent or legal guardian)

**PAYMENT POLICIES**

**PLEASE NOTE – PAYMENT IS DUE AT THE TIME OF SERVICE**

**Payment is expected at the time services are performed** unless prior arrangements have been made with the office manager. The Buchanan Family Medical Center does not routinely bill all insurances. Please check with the receptionist for a current listing of insurances that we participate with. We do bill insurance for all hospitalizations and some special procedures; however, the patient is responsible for any remaining balance on these claims. Balances not paid within 25 days of the monthly billing date may be subject to interest or finance charges.

**PAYMENT AGREEMENT**

"I have read the above policies and hereby agree to abide by these policies. In case of default of payment I promise to pay all interest and finance charges on the balance due, together with any collection cost and reasonable attorney fees incurred to effect collection on this account."

**CONSENT AND VALIDATION**

"Subject to any restrictions at the top of this page, I authorize this Doctor and his staff to conduct such exams and treatments as may be necessary for proper health care. All information on registration and medical history forms is correct to the best of my knowledge. Photocopies of such information and authorizations shall be considered as valid as the originals."

**PLEASE RETURN ALL FORMS TO THE RECEPTIONIST WHEN YOU ARE FINISHED  
THANK YOU !**

**INSURANCE AUTHORIZATION**

"I hereby authorize any holder of medical or other information about me to release information to my insurance company. I also request payment to be made to Buchanan Family Medical Center or Roy B. Parke, D.O. for services on which assignment is accepted."

"I understand that accepting assignment or "participation" with an insurance company means that Dr. Parke or the Buchanan Family Medical Center will file the claim and will collect only the amount of the insurance company's fee schedule. In that case, I understand that I am responsible for all co pays and deductible amounts along with amounts for any non-covered services. I understand that I may be asked to pay these amounts at the time of service(s) and that this provider is required by law to collect these amounts from me."

**MEDICARE AUTHORIZATION**

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to Roy B. Parke, D.O. or Buchanan Family Medical Center for any services furnished me by this provider. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and/or the Centers for Medicare and Medicaid Services and their agents any information needed to determine these benefits or benefits for related services."

"I also request that payment of authorized Medigap benefits be made either to me or on my behalf to Roy B. Parke, D.O. or Buchanan Family Medical Center for any services furnished me by this provider. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits or the benefits payable for related services."

**LABORATORY AUTHORIZATION**

If you have laboratory work ordered in our office, the testing may be performed by an outside laboratory who will bill your insurance. When information is incomplete or the insurance company does not make payment then the laboratory will bill you.

"I have read and understand the above laboratory statement. I authorize Buchanan Family Medical Center or Roy B. Parke, D.O. to release billing information to Quest, Lakeland Medical Center, or any other laboratory and I authorize my insurance carrier to make payment for laboratory services directly to such laboratory."

**"I HAVE READ THE ABOVE STATEMENTS REGARDING INSURANCE, MEDICARE, AND LABORATORY SERVICES AND MY SIGNATURE BELOW CONFIRMS THAT I AGREE WITH THE TERMS."**

Signature \_\_\_\_\_ Date \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
(parent or legal guardian)

**PLEASE RETURN ALL FORMS TO THE RECEPTIONIST WHEN YOU ARE FINISHED  
THANK YOU !**

**INSURANCE INFORMATION**

Medicare # \_\_\_\_\_ Medicaid # \_\_\_\_\_

For other insurances you may have please complete the following:

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#1 Insurance Name \_\_\_\_\_

Ins Address \_\_\_\_\_

Policy/Contract # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Phone \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Address \_\_\_\_\_ Birthdate \_\_\_\_ - \_\_\_\_ - \_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_ Sex \_\_\_\_\_

Employer \_\_\_\_\_ Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Relationship to patient: Self Spouse Parent Other (specify) \_\_\_\_\_  
(circle one)

Who pays for this policy? (circle one)

Policyholder Employer Other (specify) \_\_\_\_\_

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#2 Insurance Name \_\_\_\_\_

Ins Address \_\_\_\_\_

Policy/Contract # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Phone \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Address \_\_\_\_\_ Birthdate \_\_\_\_ - \_\_\_\_ - \_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_ Sex \_\_\_\_\_

Employer \_\_\_\_\_ Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Relationship to patient: Self Spouse Parent Other (specify) \_\_\_\_\_  
(circle one)

Who pays for this policy? (circle one)

Policyholder Employer Other (specify) \_\_\_\_\_

Do you have any other health insurance policies? Y N

**ATTENTION!! – PLEASE PRESENT ALL INSURANCE, MEDICARE, AND  
MEDICAID CARDS TO THE RECEPTIONIST TO BE COPIED FOR OUR FILES.  
PLEASE RETAIN ALL RECEIPTS IF YOU INTEND TO BILL YOUR INSURANCE!**