



**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) _____

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 _____ - _____ - _____

"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:

#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) _____

#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!**