KG Health Partners
Physician Services Group

New Patient Registration

Please have all INSURANCE CARDS and DRIVER'S LICENSE or PHOTO ID ready to copy. (PLEASE PRINT)

Today's Date: _____ Account #: _____

LAST NAME	FIRST	MI	SEX ☐ MALE ☐ FEMALE	☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED
SOCIAL SECURITY NO. - -	DATE OF BIRTH / /	RACE		☐ EMPLOYED ☐ RETIRED ☐ STUDENT
LOCAL ADDRESS	CITY		STATE	ZIP CODE
HOME PHONE	WORK PHONE	CELLULAR PHONE		
EMAIL ADDRESS	LANGUAGE PREFERENCE ☐ ENGLISH ☐ SPANISH ☐ OTHER _____ ☐ HEARING IMPAIRED ☐ VISION IMPAIRED			
PERMANENT ADDRESS	CITY		STATE	ZIP CODE
PREFERRED PHARMACY	PREFERRED PHARMACY PHONE			

IN CASE OF EMERGENCY, CONTACT:

LAST NAME	FIRST		
ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	WORK PHONE	CELL PHONE	RELATIONSHIP

IS THE PATIENT THE FINANCIALLY RESPONSIBLE PARTY? ☐ YES ☐ NO IF NO, PLEASE COMPLETE THIS SECTION

RELATIONSHIP	SEX ☐ M ☐ F	DAYTIME PHONE	
FIRST NAME	MIDDLE	LAST NAME	
ADDRESS	CITY	STATE	ZIP CODE

EMPLOYER

EMPLOYER	ADDRESS	CITY	STATE	ZIP CODE

INSURANCE INFORMATION ***PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST***

INSURANCE COMPANY		INSURED'S DOB
INSURANCE/CARD HOLDER'S NAME		RELATIONSHIP
ID #	GROUP #	PHONE

SECONDARY INSURANCE COMPANY INFORMATION

INSURANCE COMPANY NAME		INSURED'S DOB
INSURANCE/CARDHOLDER'S NAME		RELATIONSHIP
ID#	GROUP #	PHONE

IS THE REASON FOR TODAY'S VISIT THE RESULT OF AN ACCIDENT? ☐ YES ☐ NO IF YES, PLEASE COMPLETE THIS SECTION

PLEASE CHECK WHICH TYPE OF ACCIDENT: ☐ WORKERS' COMPENSATION ☐ AUTOMOBILE ☐ OTHER		
DATE OF ACCIDENT	PLACE OF ACCIDENT	HOW DID ACCIDENT HAPPEN?
CLAIM #	CLAIM REPRESENTATIVE/ADJUSTER	

IF AT WORK INJURY, PLEASE COMPLETE THIS SECTION

EMPLOYER NAME		EMPLOYER PHONE	
ADDRESS	CITY	STATE	ZIP

HOW DID YOU HEAR ABOUT OUR MEDICAL FACILITY?

☐ FRIEND ☐ TELEPHONE BOOK ☐ DRIVE BY ☐ NEWSPAPER ☐ REFERRAL BY: _____ PRIMARY PHYSICIAN _____

Please Read and Sign Back Date Scanned: _____ Initials: _____ Account Number: _____

1. CONSENT FOR TREATMENT. I understand that medical treatment of an immediate nature may be necessary for the patient and that such medical care, treatment, and procedures will be performed by licensed physicians and/or employees of KG HEALTH PARTNERS, INC/COMMUNITY HEALTH SOLUTIONS OF AMERICA during posted operating hours. I understand that medical treatment only is being provided and I hereby grant my authorization and consent to such treatment and procedures, and certify that no guarantee or assurance has been made as to the results, that may be obtained.
2. FINANCIAL RESPONSIBILITY. For and in consideration of the care and treatment provided to the patient, I promise to pay KG HEALTH PARTNERS, INC/COMMUNITY HEALTH SOLUTIONS OF AMERICA all charges for services rendered to or on behalf of the patient. Any services that are not covered by insurance are the patients' responsibility and will be due and payable at the time services are rendered unless other arrangements are made in advance. Patient is also responsible for the costs of collection of any amounts due KG HEALTH PARTNERS, INC/COMMUNITY HEALTH SOLUTIONS OF AMERICA to include reasonable attorney's fees and court costs.
3. RELEASE OF MEDICAL INFORMATION. I hereby authorize KG HEALTH PARTNERS, INC/COMMUNITY HEALTH SOLUTIONS OF AMERICA to release any medical information, in connection with these services, requested with regard to processing my claim or to my personal physician, insurance carrier, and/or attorney of record with appropriate release.
4. DIAGNOSTIC TESTING. Please be aware of YOUR insurance policy exclusions with regard to diagnostic testing. Although KG HEALTH PARTNERS, INC/COMMUNITY HEALTH SOLUTIONS OF AMERICA strives to provide our patients with any type of diagnostic testing he/she may need, certain insurance companies have specific facilities you must go to for certain tests, i.e., laboratory, X-ray procedures. It is your responsibility to verify that procedures performed at KG HEALTH PARTNERS, INC/COMMUNITY HEALTH SOLUTIONS OF AMERICA are covered by your insurance policy. The patient is ultimately held responsible for any balance due to the reason stated above.
5. MEDICARE/MEDIGAP, BLUE CROSS/BLUE SHIELD OR OTHER HEALTH INSURANCES. I hereby authorize KG HEALTH PARTNERS, INC/COMMUNITY HEALTH SOLUTIONS OF AMERICA to apply for Medicare/Medigap, and other health insurance benefits on my behalf. I hereby request reimbursements from any applicable insurance to be made directly to KG HEALTH PARTNERS, INC/COMMUNITY HEALTH SOLUTIONS OF AMERICA. I certify that the information I have provided with regard to my insurance carrier is correct. I authorize the release of medical information about me to my health insurance carrier and HCFA (Health Care and Finance Administration) agents, as well as any and all other information needed to determine the benefits payable for related service(s). I hereby authorize payment of Medigap benefits be made on my behalf to KG HEALTH PARTNERS, INC/COMMUNITY HEALTH SOLUTIONS OF AMERICA. I release any holder of Medicare information about me to my insurance carriers, necessary to determine benefits payable for related services.
6. ATTORNEY OF RECORD: I authorize my attorney to release to KG HEALTH PARTNERS, INC/COMMUNITY HEALTH SOLUTIONS OF AMERICA any information detailing my case, case status, or case settlement in connection with date of accident _____ and medical services rendered.
7. AUTHORIZATION TO APPEAL DETERMINATION: I authorize the Billing Department of KG HEALTH PARTNERS, INC/COMMUNITY HEALTH SOLUTIONS OF AMERICA to act on my behalf, as a Designated Representative, to appeal my insurance carrier's determination, if necessary. I understand that communications may contain confidential medical and financial information, including, but not limited to, treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorder and HIV status relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed. I understand the confidential information will only be released as specified in the authorization, or as permitted by law. This authorization is valid for a period of one year.
8. CONSENT TO PHOTOGRAPH: I understand that services conducted by KG HEALTH PARTNERS, INC/COMMUNITY HEALTH SOLUTIONS OF AMERICA may be photographed. The photographs are used to assist in trainings and also as an important tool of the services provided. I understand my information and identity will remain confidential and protected.
9. CONSENT TO RECEIVE AUTOMATED CALLS. I consent to receive calls from KG HEALTH PARTNERS, INC/COMMUNITY HEALTH SOLUTIONS OF AMERICA for my protected healthcare and other services at the phone number(s) listed on the front of this form, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.
10. **The policy of this facility is to call 911 for all emergencies within the medical center.**

THE UNDERSIGNED HEREBY MAKES THE FOLLOWING ACKNOWLEDGEMENTS AND AGREEMENTS REGARDING THE MEDICAL TREATMENT TO BE PROVIDED BY KG HEALTH PARTNERS, INC/COMMUNITY HEALTH SOLUTIONS OF AMERICA AND ANY OF ITS DULY AUTHORIZED AGENTS TO THE PATIENT WHOSE NAME APPEARS ON THIS FORM.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE ACKNOWLEDGEMENTS AND AGREEMENTS. I ALSO UNDERSTAND THAT IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE IMPORTANT.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Witness Account Number

☐ BROCHURE GIVEN ☐ NOTICE OF PRIVACY PRACTICES POLICY SIGNED Date Scanned:_____ Initials:_____