New Patient Registration

PERRY Medical Clinic

401 Northwood Drive, Centre, AL 35960

Phone: 256-927-3607 **Fax: 256-927-3605**

Patient Name:_____ **Date of Birth:**_____

Social Security Number:_____

Would you like us to e-mail you an invitation to our Patient Portal; Where you can view appointments, update contact and insurance information, see your bill, and view medical history?

Yes **No** **Email:**_____

Pharmacy:_____ **Phone:**_____

Emergency Contact:

Name:_____ **Relationship:**_____ **Phone:**_____

Consent to treat

I authorize the Healthcare Providers at Perry Medical Clinic, as well as the other Healthcare Professionals under their direction, to provide diagnostic evaluation and treatment. I understand that no guarantee has or will be made to me regarding any possible result or cure based on my examination/treatment.

Payment Policy

I agree to pay all amounts for services rendered to me by this Practice unless and only to the extent the Practice is otherwise obligated to accept payment from a third party. I agree to pay the attorney fees and collection costs in the event it becomes necessary to retain such services for the collection of my account.

Payment Arrangement

Payment arrangements must be made at the time of the service(s) rendered. I understand that the Practice, may assist with the filing of insurance forms, but that I am responsible for payment.

Explanation of Charges

A list of any charges will be furnished upon request

Authorization To Release Information

I authorize the release of medical information and records concerning my treatment to Medicare, Medigap, and/or other insurance companies and assign my claim for medical benefits to the Practice to the extent permitted under applicable law or insurance agreements. I agree to allow the Practice to request and release my medical records from the other physicians or medical institutions as it deems necessary for my medical care and I further authorize the release of my medical records by such parties for such purpose. I agree to allow the Practice to use my medical information and photography in an anonymous manner for purpose of teaching or publication. I release the Practice from all legal responsibility or liability that may arise from the above authorizations and agreements.

Appointment Reminder Policy

I authorize this Practice and their agents to place appointment reminder phone calls or text messages to the phone number I have listed.

Signature

Patient Signature:_____ **Date:**_____