Carl M. Shapiro, D.O.
10260 Alliance Road Suite 300
Cincinnati, OH 45242

Patient Registration Form

□ **NEW** □ **CHANGE**

PATIENT INFORMATION						
LAST NAME	FIRST NAME		MI	SEX	REFERRING DOCTOR	
SOCIAL SECURITY #	DATE OF BIRTH		AGE	HOME PHONE #		CELL PHONE #
STREET ADDRESS (please include apt #)				EMPLOYER NAME		WORK PHONE #
CITY	STATE	ZIP		EMPLOYER ADDRESS		
ALTERNATIVE CONTACT (name, address & phone number)				MARITAL STATUS _ Married _ Divorced _ Single _ Widowed _ Separated		STUDENT STATUS _ Full Time Student _ Part Time Student
EMAIL ADDRESS (if you are interested in receiving health related and/or billing information via email)						

PERSON RESPONSIBLE FOR BILL (IF OTHER THAN PATIENT)						
LAST NAME	FIRST NAME		MI	SEX	PATIENTS RELATIONSHIP TO INSURED _ Self _ Spouse _ Child _ Other _____	
SOCIAL SECURITY #	DATE OF BIRTH		AGE	HOME PHONE #		CELL PHONE #
STREET ADDRESS (please include apt #)				EMPLOYER NAME		WORK PHONE #
CITY	STATE	ZIP		EMPLOYER ADDRESS		
EMAIL ADDRESS (if you are interested in receiving health related and/or billing information via email)						

INSURANCE INFORMATION	
PRIMARY INSURANCE CARRIER	SECONDARY INSURANCE CARRIER
STREET ADDRESS OR PO BOX	STREET ADDRESS OR PO BOX
CITY STATE ZIP	CITY STATE ZIP
MEMBER ID# GROUP ID#	MEMBER ID# GROUP ID#
POLICY HOLDER'S NAME	POLICY HOLDER'S NAME
POLICY HOLDER'S SSN: DOB:	POLICY HOLDER'S SSN: DOB:

Dr. Shapiro is a Medicare provider and participates in most managed care plans. Your insurance policy is a contract between you and your insurance company. We will file your claims as a courtesy to you but ultimately you are responsible for all charges incurred. Prior to scheduling procedures and tests, we will help you confirm with your insurance carrier that any tests and procedures recommended are covered by your plan. However, you are ultimately responsible for all bills and may be responsible for out of network charges and deductibles.
Co-payments are due at the time of service. If you do not pay your co-pay at the time of service we reserve the right to assess an additional charge of $20.00 per incidence. We accept Visa, Mastercard, American Express, cash and personal checks. The fee for returned checks is $35.00.
Cancellations of less than 24 hours notice or "NO SHOWS" will be billed an office visit charge of $50.00 that is not covered by insurance and must be paid before further services are provided by our practice subject to the discretion of the practice.

CONSENT, INSURANCE AUTHORIZATION, ASSIGNMENT OF BENEFITS AND HIPPA NOTIFICATION

I authorize payment of medical benefits directly to the medical provider(s) who have treated me or rendered services or materials.

My signature below also serves as my consent to treatment and verifies that I have received a copy of this practice's HIPPA policy and that my questions concerning HIPPA have been adequately answered.
I also received a copy of this practices HIPPA policy and Required Disclosure for Medicare Conditions of Coverage for any physician owned entity where this practice delivers care and that my concerning these documents have been adequately answered.

Signature: _____ **Date:** _____