Darrell Parsons, M.D., P.A.
318 N ALLEGHANEY, STE 100
ODESSA, TEXAS 79761
432-640-2929 Office
432-640-2379 Fax

PATIENT REGISTRATION FORM

Please present proof of insurance, Medicare and/ or Medicaid. Payment is expected at the time of services.

Patient Information

Name: _____

Address _____

City _____State _____ Zip _____

Marital Status _____

Phone _____

Alt Phone1 _____

Alt Phone2_____

Date of birth _____ Age _____Sex _____

Drivers License# _____

Social Security Number _____

Patient employer

Employer _____

Occupation _____

Address _____

City _____

Phone_____

Patient's spouse/ Guardian

Spouse/Guardian _____

Relationship _____

Address _____

Alt Phone _____

Responsible/Insured Party (if other than patient)

Name: _____

Address: _____

City: _____State _____ Zip _____

Employer: _____ phone _____

Address _____

City _____State _____Zip _____

Soc. Security Number: _____

Emergency Contact Party Information

Contact name_____

Relationship _____

Phone Number _____

Alt Phone1 _____

Alt Phone2 _____

I certify the above information is correct t o the best of my knowledge. I also understand that I am financially responsible for any balance and charges whether cover or not cover by insurance.

I request thatpayment of my insurance benefits be made on my behalf the office of Darrell Parsons, M.D. P.A., for any services furnished me by that group of physicians.

Signed _____Date_____

(Guardian) _____

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Patient Name:_____ DOB: _____

1) We ask that you present your insurance card at each visit. It's your responsibility to provide us with the correct information to bill your insurance.
2) If you have a change of address, telephone numbers, or employer, please notify the receptionist.
3) We will collect your deductible, Co-payment or charge for non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will ask for that payment. We accept cash, checks, visa, and Master card.
4) If we do not participate in network with your insurance company, you will be expected to make your payment in full at the time the service is rendered.
5) If your insurance denies our charge or does not pay us in a timely manner, or if your account becomes delinquent, we reserve the right to refer your account to a collection agency.
6) MEDICARE PATIENTS: We are participating providers with Medicare and will bill Medicare for all your covered charges. If you have a supplemental insurance, we will also bill that for you. If payment is not received from your supplemental insurance within 45 days of being submitted, we will bill you for the balance due. If you do not have a supplemental insurance, your portion (20 % amount allowed by Medicare) will be collected at the time of services. Each year you will be expected to pay the allowed amount of your charges until Medicare deductible is met.
7) PPO PATIENTS: If we participate with your plan, we will bill your insurance for you. Your Co-payment will be collected at the time of service. If your plan requires you to choose a primary care physician, it is **your** responsibility to make sure your insurance company has the physician you are seeing in our office as your PCP. If your plan requires you to have an authorization to see a specialist, you still need to obtain that from our office prior to seeing the specialist. No retroactive referrals will be given. If we not participate with your plan, we will verify your out-of-network benefits, file your charges, and we will expect payment of your portion of the charges at the time of services. If we are not the primary care physician, we will not be able to obtain an authorization to see a specialist or admit you to a hospital.
8) SELF-PAY PATIENTS: Patients with no insurance will be expected to pay at the time of service. If you will not be able to pay in full, you must contact the office in advance prior to seeing the doctor and nurses to make payments arrangements.
9) No show or missed appointments: When an appointment is scheduled with the doctor, the time is specifically allocated for you. When an appointment is not canceled in advance, and the patient is "no show", another patient that needed to be seen may have been unable to because the time slot was already taken. We understand there many times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel appointments by you.
10) Your insurance is contract between you, your employer and the insurance company. **We are not a party to that contract.** It's very important that you understand the provisions of your policy. We cannot guarantee payment of all claims. If your insurance pays only a portion of the bill or rejects our claim, any contact or explanation should be made to you, their policy holder. Reduction or rejection of your claim by your insurance does not relieve you of your financial obligation.

Remember, whether you do have or do not have insurance, you are ultimately financially responsible for payments.

I have read and understand the financial policy of the office of Darrell Parsons, M.D., P.A.

Signature: _____ Date: _____

Printed Name if signed by Guardian:_____