Phillips Clinic
Be well. Stay well. Age well.

5970C S. Rainbow Blvd. Suite 100
Las Vegas, Nevada 89118
(P) 702-363-4000
(F) 702-362-0086
www.phillipsclinicly.com

PATIENT REGISTRATION FORM

PATIENT INFORMATION PLEASE PRINT **REFERRED BY** ______________________

Name (Last)______________________________(First)______________________(MI)__________ Date of Birth____________________

Address____City______________________State_________Zip_____________

Home Phone (_____)________________ Cell Phone (_____)________________ Social Security #__________________ Age_________

Sex ___________ Marital Status_________________________ Personal Email____

EMPLOYER INFORMATION

Employer____ Address____

City____State_______________Zip____________ Phone (_______)______________________

RESPONSIBLE PARTY INFORMATION

Name____ Relationship to Patient_____________________________________

City____State_______________Zip____________ Phone (_______)______________________

Date of Birth____________________ Social Security #_____________________ Employer_________________________________

NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU

Name____ Relationship to Patient_____________________________________

City____State_______________Zip____________ Phone (_______)______________________

PRIMARY INSURANCE

Company Name____ Ins. Effective Date___________________________

Address____City_______________State______Zip________ Phone (_____)_____________

Insured's Information

Name______________________________________ Relationship to Patient______________________ Date of Birth_________________

Sex ☐ M or ☐ F Address____City_____________State_________Zip____________

ID#_________________________________ Group#_______________________________ Employer______________________________

SECONDARY INSURANCE

Company Name____ Ins. Effective Date___________________________

Address____City_______________State______Zip________ Phone (_____)_____________

Insured's Information

Name______________________________________ Relationship to Patient______________________ Date of Birth_________________

Sex ☐ M or ☐ F Address____City_____________State_________Zip____________

ID#_________________________________ Group#_______________________________ Employer______________________________

OTHER INSURANCE

Company Name____ Ins. Effective Date___________________________

Address____City_______________State______Zip________ Phone (_____)_____________

Insured's Information

Name______________________________________ Relationship to Patient______________________ Date of Birth_________________

Sex ☐ M or ☐ F Address____City_____________State_________Zip____________

ID#_________________________________ Group#_______________________________ Employer______________________________

ATTESTATION STATEMENT

I certify that the preceding registration and insurance information is true and correct. I authorize Phillips Clinic to provide this and all other necessary information to my insurance company for use in claim processing. A photostatic copy of this information shall be considered as effective and valid as the original.

ASSIGNMENT OF BENEFITS

I guarantee payment of all charges.
I assign and direct to pay any and all benefits for all claims directly to Phillips Clinic.
I hereby authorize the release of any information requested by the insurance company(ies) with this assignment.

MISSED APPOINTEMENTS AND OFFICE STUDIES/PROCEDURES

Please call our office at least 24 hours in advance if an appointment cannot be kept.
I understand that a fee of **$25.00** will be charged to me if I fail to notify the office.
I understand that there is an applicable fee for late cancellations or missed office studies and procedures.

RETURNED CHECKS

I understand that a fee of $25.00 will be charged for each returned check.

RECORDS RETENTION

Pursuant to the provisions of subsection 7 of NRS 629.051,
"The health care records of a person who is less than 23 years may not be destroyed: and the health care records of a person who has attained the age of 23 may be destroyed for those records which have been retained for at least 5 years or longer period provided by federal law; and except as otherwise provided in subsection 7 of NRS 629.051 and unless a longer period provided by federal law, the health care records of a patient who is 23 years of age or older may be destroyed after 5 years pursuant to subsection 1 of NRS 629.051."

HIPPA ATTESTATION

By signing below I acknowledge that I have received the Notice of Privacy Practices.

ADVANCED DIRECTIVE

Do you have an advanced directive? ☐ Yes ☐ No

Would you like advanced directive information? ☐ Yes ☐ No

ABOUT YOUR INSURANCE

Your insurance policy is a contract between you and/or your employer and the insurance company. We are not a party to that contract. Our relationship is with you, and you are ultimately responsible for any service provided, regardless of your insurance coverage. As a courtesy to you, we will submit an insurance claim on your behalf if you assign the benefits to us. This means that you agree to have your insurance company pay us directly for the services we provide. However, it is your responsibility to follow-up with your insurance company in the event that your claim is unpaid. If your insurance company changes, it is your responsibility to notify us and provide a copy of the new insurance card to us immediately.
Please note that not all health plans cover the same services. In the event that your health plan determines a service is "not covered," you will be responsible for the total charge. It is your responsibility to know what is covered and what is not covered. Payment is due in full at the time of service unless other arrangements have been made.

Patient/Responsible Party

Print Name ____

Signature ____

Witness Signature _______________________________________

Date ____