Welcome to Advocate Medical Group
Patient Registration

Advocate Medical Group®

PRIMARY PHYSICIAN NAME (LAST, FIRST) AND OFFICE LOCATION (CITY)	DATE

Patient Information *(please print)*

PATIENT NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	GENDER M F

ADDRESS & UNIT NUMBER IF APPL.	CITY, STATE, ZIP CODE

MOBILE (CELL) CAN WE LEAVE A MESSAGE WITH HEALTH INFORMATION? YES NO	OTHER PHONE NUMBER CAN WE LEAVE A MESSAGE WITH HEALTH INFORMATION? YES NO

EMAIL ADDRESS (USED FOR PORTAL ACCOUNT/COMMUNICATION)	MARITAL STATUS

PREFERRED LANGUAGE	RACE (Optional)	ETHNICITY (Optional)

Account Guarantor if not the patient

GUARANTOR OF ACCOUNT (FINANCIALLY RESPONSIBLE PARTY)

NAME: _____ ADDRESS: _____ APT. / SUITE: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: _____

Primary and Secondary Insurance with Subscriber Info (attach a copy of both sides of insurance cards)

	Primary Insurance	Secondary Insurance
Insurance Name		
Insurance Address		
Insurance City/State/Zip		
Group Number		
Policy Number		
Effective Date		
Subscriber's Name		
Subscriber's Date of Birth		
Relationship to Patient		

Emergency Contact

EMERGENCY CONTACT NAME (LAST, FIRST)		RELATIONSHIP TO PATIENT
CELL PHONE NUMBER	HOME PHONE NUMBER	WORK PHONE NUMBER

I authorize Advocate Medical Group to disclose my Patient Health Information to the following person(s)

NAME: _____ PHONE NUMBER: _____ RELATIONSHIP: _____

NAME: _____ PHONE NUMBER: _____ RELATIONSHIP: _____

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize Advocate Medical Group and its agents to release any medical or incidental information that may be necessary for either medical care, to submit a health insurance claim, in processing applications for financial benefit, for quality assurance, or for Advocate Medical Group review for the purpose of medical research.

APPLICABLE TO MEDICARE PATIENTS:
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare program or its intermediaries or carriers any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf.

ASSIGNMENT OF BENEFITS:
I hereby authorize direct payment of surgical/medical benefits to Advocate Medical Group for services rendered. I understand that I am financially responsible to Advocate Medical Group for charges not covered by this assignment. In some cases, your provider's fee is not covered in full by your insurance company. This balance due includes provisions set by your insurance company such as copayments, deductibles, and "usual and customary" allowance.

GUARANTEE OF PAYMENT:
In consideration of all medical services given by Advocate Medical Group to the patient named above, I agree to pay to Advocate Medical Group all fees and charges made for services, which may include the cost of collection and/or reasonable attorney's fees. Payment is due and payable within 30 days of billing date. A late charge may be added to the account for all charges not paid within 90 days.

I hereby certify that the foregoing information is true and complete. I have read and hereby agree to be bound by the terms of these agreements as set forth. A photocopy of this form shall be valid as the original. I understand that it is my responsibility to notify Advocate Medical Group of any changes to the above information.

CANCELLATION FEE: IF YOU ARE UNABLE TO MAKE YOUR APPOINTMENT WE DO REQUIRE A 24 HOUR NOTICE IN ORDER TO AVOID A CANCELLATION FEE

SERVICE CHARGE: A $25.00 SERVICE CHARGE PER RETURNED CHECK WILL BE ASSESSED

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: _____ DATE: _____

PRINT NAME OF PATIENT OR RESPONSIBLE PARTY: _____