Dr Stefana Pecher, LLC
Country Doc Walk-In & Wellness LLC
391 Norwich Westerly Road PO Box 417
North Stonington, CT 06359
Tel: (860) 535-4600
Tel: (860) 245-4466

PATIENT REGISTRATION FORM

Fax: (860) 535-4605
Fax: (860) 245-4468

Please complete this form in order to ensure proper billing of your services. PLEASE PRINT. Today's Date: _____

Patient Name: _____ Social Security Number: _____
Last Name, First Name, MI

Other Name: _____ Date of Birth: _____

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other

Addr1: _____ Home Phone: _____

Addr2: _____ Daytime Phone: _____

City, St, Zip: _____ Cell Phone: _____

Employer: _____ Emp. Status: ☐ Employed ☐ Unemployed ☐ Disabled

Addr1: _____ ☐ Homemaker ☐ Student ☐ Active Military ☐ Self-Employed

Addr2: _____ ☐ Other: _____

City, St, Zip: _____ Work Phone: _____

Pharmacy: _____ City: _____ State: _____

Email Address: _____

Please complete if guarantor is other than self. (The guarantor is the person financially responsible for this patient's bill.)

Guarantor: _____ Patient's Relationship to Guarantor: _____

Addr1: _____ Social Security Number: _____

Addr2: _____ Date of Birth: _____

City, St, Zip: _____ Sex: _____

Home Phone: _____ Work Phone: _____

Employer: _____

Addr1: _____ Addr2: _____

City, St, Zip: _____

Emergency Contact: _____ Patient's relationship to Emergency Contact: _____

Addr1: _____ Home Phone: _____

Addr2: _____ Work Phone: _____

City, St, Zip: _____ Cell Phone: _____

Medical Power of Attorney: _____

Phone: _____

Living Will/Advance Directive: _____

Insurance Information

A separate form is required for Worker's Compensation, Automobile Liability, or Legal Services.

PRIMARY CARRIER: _____

Subscriber ID#: _____ Group #: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Relationship to Patient: _____ Effective Date: _____

SECONDARY CARRIER: _____

Subscriber ID#: _____ Group #: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Relationship to Patient: _____ Effective Date: _____

Primary Care Physician/Referring Physician

PCP: _____ Refer. Phys. (if different): _____

Telephone #: _____ Telephone #: _____

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AUTHORIZATION OF BENEFITS FINANCIAL POLICY
RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Medicare We accept Medicare assignment. As a Medicare patient you are responsible for your deductible and for the difference between the allowable charge and the amount Medicare pays. If you have a supplemental insurance, we will bill that for you. Any remaining balance will be your responsibility. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr Stefana Pecher, LLC and/or Country Doc Walk-In & Wellness LLC for any services furnished to me. I authorize any holder of medical information about me to release to Dr Stefana Pecher, LLC and/or Country Doc Walk-In & Wellness LLC and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or the party who accepts assignment.
All patients who subscribe to Medicare and/or any Medicare insurance products will be asked to sign an ABN (Advance Beneficiary Notice of Noncoverage) form.

In order to comply with Medicare regulations, please answer the following questions:

Are you or your spouse employed?	□ YES □ NO
Has treatment been authorized by the V.A.?	□YES □ NO
Do you or your spouse have other insurance?	□ YES □ NO
Are you covered under the Black Lung Program?	□YES □NO
Are you disabled or have end stage renal disease?	□ YES □ NO
Is illness/injury the result of an auto accident?	□ YES □ NO
Is there insurance coverage primary to Medicare?	□YES □NO
Did illness/injury occur at work?	□ YES □ NO
Is there employer supplemental coverage 2ndary to Medicare?	□ YES □ NO

HMO/PPO/Commercial The patient is responsible for verifying what services your insurance plan will cover and that we are participating providers in your plan. All co-payments and account balances are due at time of service. I hereby authorize payment directly to Dr Stefana Pecher, LLC and/or Country Doc Walk-In & Wellness LLC for medical benefits including any Major Medical benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to the physician. In making this assignment, I understand and agree that I am financially responsible to the above party for charges not paid under this insurance policy. I permit a copy of this authorization to be used in place of the original.

Workers Compensation If you are here as a result of work related injury; we will require information regarding both health insurance and your employers Workers Compensation Insurance. We required a claim number, insurance address, adjuster's name and phone number. If payment is not received, the balance is your responsibility.

Accident Claims If you are being treated for an auto related injury; we will require information regarding both health and auto insurance. We will required a letter authorizing treatment from your auto insurance including claim number, adjuster's name and phone number. If payment is not received, the balance is your responsibility

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Consent for Medical Treatment I authorize Dr Stefana Pecher, LLC and/or Country Doc Walk-In & Wellness LLC and personnel to render medical treatment and evaluation if needed for this appointment and all future appointments.
I further authorize other diagnostic tests and treatment that may be necessary.
I authorize the release of any medical information necessary to process insurance claims.
I authorize release of information to physicians or health care providers to who I may be referred.
I authorize release of information to my employer if this is a work related condition.
I understand and agree to pay a fee of $10.00 for any additional forms the provider may need to fill out, if not presented at time of visit.
This authorization shall remain in effect until rescinded by patient or authorized individual.

Release of Information Dr Stefana Pecher, LLC and/or Country Doc Walk-In & Wellness LLC may disclose any or all parts of my clinical records to my insurance company or companies, or, in the case of Worker's Compensation claims, to my past or present employer(s), for purposes of satisfying charges billed by Dr Stefana Pecher, LLC and/or Country Doc Walk-In & Wellness LLC. This authorization does not cover requests from other parties seeking information regarding my account.

Guarantee of Account For and in consideration of services rendered by Dr Stefana Pecher, LLC and/or Country Doc Walk-In & Wellness LLC to the below named patient, the undersigned (jointly and severally if more than one) guarantees payment of all charges incurred for said patient in accordance with the policy of payment of bills.

Missed and Canceled Appointments, Returned Checks There will be a fee of $50.00 charged for all missed (No Show) appointments and appointments canceled under 24 hours. There will be a $20.00 fee charged for any returned (bounced) check.

IT IS THE RESPONSIBILITY OF THE PATIENT TO KNOW WHAT THEIR INSURANCE PLAN COVERAGE IS. OUR BILLING DEPARTMENT WILL SUBMIT TO YOUR INSURANCE; HOWEVER, THE PATIENT IS RESPONSIBLE FOR ANY REMAINING BALANCE.

THE UNDERSIGNED CERTIFIES THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS.

Patient Signature **Date**

Patient's Agent, Representative and/or Guarantor's Signature **Date**