



INTERNAL MEDICINE:  
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Thomas Leffingwell, M.D. Joe  
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Kent Rasmussen, M.D.

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## Patient Registration

Date \_\_\_\_\_ Physician \_\_\_\_\_

Name \_\_\_\_\_ Marital Status \_\_\_\_\_

Birth Date \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Can all medical correspondence be mailed to the above address? Yes \_\_\_\_\_ No \_\_\_\_\_

If not, please list preferred address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse/Guardian's Name \_\_\_\_\_

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Primary Insurance Company \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birth Date \_\_\_\_\_ SSN \_\_\_\_\_ Employer \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_ Phone \_\_\_\_\_

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Secondary Insurance Company \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birth Date \_\_\_\_\_ SSN \_\_\_\_\_ Employer \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_ Phone \_\_\_\_\_

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In case of emergency, please notify \_\_\_\_\_ Phone \_\_\_\_\_

Do you have a: 1) Do Not Resuscitate Document? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, where are they on file: \_\_\_\_\_

2) Living Will? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, where are they on file: \_\_\_\_\_

Do you have other family members who are patients of any of the above listed doctors in the group? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please list family member's name and physician \_\_\_\_\_

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## Patient Consent for the Disclosure of Information

I have read the NOTICE OF PRIVACY PRACTICES and have had any questions answered by this office. I understand that by signing this form I consent to the following:

1. **Sharing Information for Purposes of Treatment:** You will share my information with all members of my treatment team, both within this office and with other providers (personal and institutional) in order to provide me with quality care and the **educational/wellness programs specified in my insurance plan;**
2. **Sharing of Information for Purposes of Payment:** You will share all necessary information with my insurer(s), payor(s), governmental-entities (such as Medicare, Medicaid, etc.) and their representatives (including, but not limited to benefit determination and utilization review) as well as your representatives involved in the billing process (including, but not limited to) claims representatives, data warehouses, billing companies);
3. **Sharing of Information For Purposes of Operations:** You will share all information necessary for ongoing operations of this office, including (but not limited to) the credentialing processes, peer review, accreditation and compliance with all federal and state laws.

My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

\_\_\_\_\_  
Patient's Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature (Or Guardian, if a minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness (Optional)

\_\_\_\_\_  
Date

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## Explanation of Patient Financial Responsibility

In order to maintain the lowest possible fee structure, we feel our patient's understanding regarding financial responsibility is imperative. Hopefully, the following information will help you understand the established clinic policies. We encourage you to discuss any comments, questions, or concerns regarding our financial policy with us.

- You must pay any co-pay or deductible at the time of service.
- If you are not insured or on a plan that our clinic does not participate with, you will be expected to provide payment in full at the time of service.
- Your charges will be submitted to your health plan for direct payment to our office.
- If your health plan remits payment to you, please provide payment amount to the clinic along with a copy of the explanation of benefits.
- Your health plan may refuse payment of a claim for any of the following reasons:
  1. Diagnosis is a pre-existing illness which is not covered by your plan.
  2. You have not met your full calendar year deductible.
  3. The type of medical service or diagnosis is not covered by your plan.
  4. The health plan was not in effect at the time of service.
  5. You have other insurance which must be filed first.
  6. We do not participate in your plan or you did not elect our doctor as your PCP.

Please understand that financial responsibility for medical services rests on you, the patient. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage. Any verification of benefits provided by your insurance carrier is not considered to be a guarantee of coverage. If your health plan denies a claim for any reason, it is your responsibility as a patient to pay the denied amounts in full.

Our primary mission is to provide you with quality, cost effective, medical care. We strive to continually adapt our policies to the changing way that health care is delivered and financed. We value you as a patient and will work diligently to address all of your medical and financial needs.

I have read and understand the above policies. I understand that: a) I am fully responsible to pay all charges incurred for medical services rendered regardless of insurance coverage and b) Arlington Physicians, P.A. (APPA) is not obligated to process my insurance, but will do so solely as a courtesy to me. In the event of an unpaid bill, I agree to pay APPA all costs and fees incurred to collect the bill. I understand there will be a \$30 charge for returned checks. I hereby authorize APPA to a) furnish all information to insurance companies concerning medical services rendered to me, and b) apply for benefits on my behalf for medical services rendered. I request all such payments be made directly to APPA.

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Signature of Patient

Date

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Printed Patient Name