Thomas Jefferson University | Jefferson University Physicians

Account No.	Entered Date
Reg. By	Office Site

JUP Patient Registration Form

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

Patient Name: _____ (Last Name) Social Security Number: _____

First Name: _____ MI Date of Birth: _____ Sex: ☐ M ☐ F

Other Name: _____ Race: (**Response is not mandatory. Data is used for statistical reporting.**)

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other

☐ African American ☐ Asian/Oriental ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other ☐ Unknown

Addr1: _____ Home Phone: (_____) _____

Addr2: _____ Other Phone: (_____) _____

City, State, Zip: _____

Home E-mail: _____ Home Fax: (_____) _____

Employer: _____ Emp Status: ☐ Employed Full Time ☐ Employed Part Time

Addr1: _____ ☐ Unemployed ☐ Disabled ☐ Homemaker

Addr2: _____ ☐ Student ☐ Active Military ☐ Self-Employed ☐ Other _____

City, St, Zip: _____ Work Phone (_____) _____

Please complete if guarantor is other than self. (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: _____

Emerg Cont: _____ Patient's Relationship to Emerg Cont: _____

Addr1: _____ Home Phone: (_____) _____

Addr2: _____ Work Phone: (_____) _____

City, St, Zip: _____

How did you hear of our practice? ☐ Billboard ☐ Brochure ☐ Health Fair ☐ Health Plan ☐ Internet ☐ Jeff NOW® ☐ Mass Mailing ☐ Newspaper/Mag. ☐ Ongoing Care ☐ Other ☐ Patient ☐ Phone Bk ☐ Phys. Off./ER ☐ Relative ☐ Radio ☐ TV ☐ Word of Mouth

Insurance Information

A separate form is required for workers' compensation, automobile liability, or legal services.

PRIMARY CARRIER: _____

Address: _____ Telephone #: (_____) _____

Group/Plan #: _____ ID/Cert #: _____

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

Relationship to Patient: _____ Effective Date: _____

SECONDARY CARRIER: _____

Address: _____ Telephone #: (_____) _____

Group/Plan #: _____ ID/Cert #: _____

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

Relationship to Patient: _____ Effective Date: _____

Primary Care Physician / Referring Physician

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

Addr: _____ Addr: _____

City, St, Zip: _____ City, St, Zip: _____

Telephone #: _____ Telephone #: _____

Thomas Jefferson University | Jefferson University Physicians

JUP Patient Signature on File Form

Medicare

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Jefferson University Physicians and/or to the individual Attending Physician, for any services furnished to me by that Physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration 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.

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

Are you or your spouse employed?	☐ Y	☐ N	Has treatment been authorized by the V.A.?	☐ Y	☐ N
Do you or your spouse have other insurance?	☐ Y	☐ N	Are you covered under the Black Lung Program?	☐ Y	☐ N
Are you disabled or have end stage renal disease?	☐ Y	☐ N	Is there Medigap coverage secondary to Medicare?	☐ Y	☐ N
Is illness/injury the result of an auto accident?	☐ Y	☐ N	Is there insurance coverage primary to Medicare?	☐ Y	☐ N
Did illness/injury occur at work?	☐ Y	☐ N	Is there employer supplemental coverage secondary to Medicare?	☐ Y	☐ N

Medigap (Medicare Secondary Insurance)

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Jefferson University Physicians for any services furnished to me by that physician. I authorize any holder of Medicare information about me to release to my Medigap Coverage any information needed to determine these benefits payable for related services.

Pennsylvania Medical Assistance

I understand that payment for service(s) or items received will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State laws.

Commercial

Assignment of Insurance Benefits

I hereby authorize payment directly to Jefferson University Physicians 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 physicians. In making this agreement, 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.

General

Release of Information

I hereby authorize Jefferson University Physicians to disclose to my insurance company(s) copies of my medical records(s) to obtain payment for services or as part of a post-payment review of medical services, or in the case of Workers Compensation claims, to my present or past employer(s). Additionally, I authorize Jefferson University Physicians to release copies of my medical record(s) to other health care providers serving as consultants to my physician, including referrals for treatment. I recognize that the information disclosed may be protected by federal and/or state law, and I specifically consent to disclose of such information. I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance upon it.

Use of Photograph

The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's medical record and may be used by the patient's health care provider solely for purposes of patient identification.

Financial Agreement

In consideration of the services rendered to the below named patient, the undersigned agrees to pay Jefferson University Physicians in accordance with its regular charges and terms and, if this account is referred to an attorney or agency for collection, to pay attorney(s) fees, court costs, and collection expenses. I also agree to be responsible for charges not covered by insurance. I understand that my obligation to pay Jefferson University Physicians may not be deferred for any reason, including pending legal action against other parties, to recover medical costs.

The undersigned certifies that each has read and understands the above terms and conditions.

X _____
Patient Signature Date

X _____
Patient's Agent Representative and Guarantor Signature Date

***Please give your insurance card to the receptionist for copying.**