PATIENT REGISTRATION

All Information is Confidential

Patient Name: (Last) _____ (First) _____ (MI) _____

Name you prefer to be called: _____

Patient Physical Address: _____

City: _____ State: _____ Zip: _____

Home Phone No.: _____ Cellular Phone No.: _____

Drivers' License #: _____

Email Address: _____

Date of Birth: _____ Age: _____ Sex: M F

Employment Information:

Patient Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work Phone No.: _____ Ext.: _____

Emergency Contact

Relationship to Insured: _____ First and Last Name: _____

Home Phone No.: _____ Work Phone No.: _____ Cell Phone No.: _____

Financial Policy/Payment Responsibility

Thank you for selecting Rochester Medical Weight Loss, P.C. ("RMWL") for your Medical Weight Loss treatment. RMWL does not contract with any insurance plans (including, without limitation, Health Maintenance Organizations (HMOs), Point of Service Plans (POSs), Preferred Provider Organizations (PPOs) or Preferred Provider

Networks (PPNs), and is not a Medicaid provider. Therefore, patients accepted to our practice are personally responsible for payment to RMWL. If you have signed up for a specific program or plan, the amount due will be as specified for that program or plan. By signing below, you agree that if accepted as a patient of RMWL, you will be personally responsible for payment of amounts due RMWL. Payment is due at the time services are rendered. Any unpaid balance will be billed to you personally and not to any insurance company or other third party payor. For your convenience, we accept Visa, MasterCard, and Discover, cash or checks.

Some insurance plans may permit patients of RMWL to submit claims for services provided by us or for ancillary services ordered as part of your treatment (such as blood tests, etc.). If you insurance plan is one of these plans, RMWL will provide you with a statement that you can submit to your insurance plan in accordance with the plan's rules. However, the provision of such statement does not relieve you of the responsibility for payment of amounts due RMWL.

By signing below, you represent to RMWL that you are not enrolled in Medicare or a Medicare Advantage Plan. You acknowledge that if, while a patient of RMWL you enroll in Medicare of a Medicare Advantage plan, you may elect to obtain medical care from a health care provider who is accepting Medicare and Medicare Advantage Plan enrollees, rather than receiving medical care from RMWL. However, no fees previously paid are refundable.

I have read and understand all of the above. I agree to be responsible for payment to RMWL for the services rendered to me as provided for above.

Date: _____

Patient Signature: _____

Office Personnel/Witness: _____

If the Patient is a minor or incompetent, the Patient's parent or legal guardian must sign below indicating the parent or guardian's acceptance of the above terms and agreement to pay the amounts due on behalf of the Patient:

_____
Signature of Parent or Person with authority to consent for patient

Print Name: _____
Relation to Patient: _____