Robert W. Herring, Jr., M.D.
PATIENT REGISTRATION

(DOCTOR with whom you have an appointment) _____ **Date** _____ **Account #** _____

1. Referring/Primary Doctor _____
   Address _____
(Must have) **Phone #** ( ) _____
2. Referral Agency (please provide name) _____
   _____
3. Friend _____

4. Emergency Room _____
5. Yellow Pages _____
6. Other (please specify _____
   _____

PATIENT INFORMATION

Name _____ Phone: ( ) _____
(Last) (First) (Middle)
Address _____ Email _____ Cell Ph.: ( ) _____
City _____ State _____ Zip _____ County _____ Pager: ( ) _____
Sex: _____ Age: _____ Date of Birth _____ Social Security #: _____
Marital Status: _____ Do you have a living will or advance directive ? ☐ YES ☐ NO (**If yes, please provide us with a copy**.)
(Must have the above information)

EMPLOYMENT INFORMATION

Please Circle One: not employed fulltime parttime self employed active military or retired? RETIREMENT DATE _____

Employer's Name: _____ Phone: ( )_____ ext. or dept.: _____
Address: _____

RESPONSIBLE PARTY (If different from patient)

Name: _____
(Last) (First) (Middle)
Address: _____ Phone: ( ) _____
City _____ State: _____ Zip _____ County: _____
Sex: _____ Age: _____ Date of Birth _____ Social Security # _____
Marital Status _____ Relationship to Patient: _____

RESPONSIBLE PARTY EMPLOYMENT INFORMATION

Please Circle One: not employed fulltime parttime self employed active military or retired? RETIREMENT DATE _____

Employer's Name: _____ Phone: ( )_____ ext. or dept.: _____
Address: _____

SPOUSE INFORMATION

Name: _____
(Last) (First) (Middle)
Address: _____ Phone: ( ) _____
City _____ State: _____ Zip _____ County: _____
Sex: _____ Age: _____ Date of Birth _____ Social Security #: _____ _____
Marital Status _____

SPOUSE EMPLOYMENT INFORMATION

Please Circle One: not employed fulltime parttime self employed active military or retired? RETIREMENT DATE _____

Employer's Name: _____ Phone: ( )_____ ext. or dept.: _____
Address: _____

FRIEND OR RELATIVE NOT LIVING WITH YOU

Name: _____ Relationship : _____
Address: _____ Daytime Phone: ( ) _____

INSURANCE INFORMATION

DO YOU HAVE MEDICARE? ☐ NO ☐ YES Medicare #: _____
DO YOU HAVE MEDICAID? ☐ NO ☐ YES Medicaid #: _____

PRIMARY INSURANCE COMPANY:
Insured Name: _____ Relationship to insured: _____
Date of Birth: _____
Name of Insurance Company: _____ Phone: ( ) _____
Address: _____

(Must have) **Patient ID #:** _____ **Group #:** _____

Is pre-certification required for services? ☐ Yes ☐ No
Is a referral number required for services? ☐ Yes ☐ No
Is policy a PPO (Preferred Provider Organization? ☐ Yes ☐ No
Is policy a HMO (Health Maintenance Organization? ☐ Yes ☐ No

Does your insurance require a specific lab or pathologist?
☐ Yes ☐ No If yes, please specify:
_____

PATIENT NAME: _____ Account #: _____

INSURANCE INFORMATION CONTINUED

SECONDARY INSURANCE COMPANY:

Insured: Name: _____ Relationship to insured: _____

Birthdate: _____

Name of Insurance Company: _____ Phone: (____)_____

Address: _____

Patient ID #: _____ Group #: _____

Is precertification required for service? ☐ Yes ☐ No
Is a referral number required for service? ☐ Yes ☐ No
Is policy a PPO (Preferred Provider Organization)? ☐ Yes ☐ No
Is policy an HMO (Health Maintenance Organization)? ☐ Yes ☐ No

OTHER INSURANCE COMPANY:

Insured: Name: _____ Relationship to insured: _____

Birthdate: _____

Name of Insurance Company: _____ Phone: (____)_____

Address: _____

Patient ID #: _____ Group #: _____

Is precertification required for service? ☐ Yes ☐ No
Is a referral number required for service? ☐ Yes ☐ No
Is policy a PPO (Preferred Provider Organization)? ☐ Yes ☐ No
Is policy an HMO (Health Maintenance Organization)? ☐ Yes ☐ No

I authorize the release of any medical information necessary to process insurance claims. I further authorize payment of medical benefits to the physician and/or Facility in the event they file for the insurance.

_____ Date _____
Patient's or Authorized Individual's Signature

I have been provided a copy of my doctor's practice brochure which lists his credentials as well as practice information.

_____ Date _____
Patient's or Authorized Individual's Signature

MEDICARE PATIENTS

Patient Name: _____ Medicare #: _____

Medicare will only pay for certain services that it determines to be "reasonable and necessary" under Section 1862 (a)(1) of the Social Security Act. If Medicare determines that a particular service, although it would be otherwise covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for it.

Medicare is likely to deny payment for the following services:

1. Procedure Code: A9150: Description: Procedure prep kit.
   Reason: Medicare lists prep kits as a "supply item". These kits are, in fact, a medical necessity item for the procedures performed by your physician.

2. Procedure Code: 99000 Description: lab handling fees.
   Procedure Code: 36415 Description: venipuncture.
   Reason: medicare dose not allow physicians' offices to bill for lab work, handling and/or for the shipping to the laboratory for processing. The venipuncture fee and the handling fee are legitimate expenses incurred by the physician's office to insure that your lab work is drawn properly, and received promptly by the laboratory. Medicare will be billed separately by the laboratory for the performance of your lab tests.

I agree that I have been notified by my physician that he/she believes that in my case Medicare is likely to deny payment for the services identified above for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

_____ Date _____
Patient's or Authorized Individual's Signature