FAMILY CARE OF BLACK MOUNTAIN/OLD FORT
INSURANCE REGISTRATION FORM

NAME:
Last: ___________________________ First: ________________________ Middle: ______________ Suffix: _______

Address: _____________________________________City: ______________________St.______ Zip_____________

Home Phone: ___________________Birth Date: _____/____/________Age: _________Sex: [ ] M [ ] F

PRIMARY INSURANCE

Company Name: ____ Effective date _______/________/_________

Certificate /ID number______________________ Group number _________________ Plan ID ______________

Policy Holder___________________________ Relation to insured ___________ Birth Date____/_____/______

SECONDARY INSURANCE

Company Name: ____ Effective date ________/_______/_________

Certificate /ID number______________________ Group number ________________ Plan ID ______________

Policy Holder____________________________ Relation to insured ____________Birth Date_____/____/____

ASSIGNMENT OF BENEFITS:

I hereby authorize direct payment of benefits to Family Care of Black Mountain/Old Fort for services rendered to me. I understand that I am financially responsible for any balance not covered by my insurance.
I understand there will be a fee incurred for a missed appointment: $75.00 for a Physical appointment, or $25.00 for regular office visits.

Patient/Guardian
Signature____Date______________________________