Patient Registration

Last Name:	First Name:	MI:	Email:

Date of Birth:	Gender:	Social Security Number:
	☐ Male ☐ Female	

Vocational Category:	Marital Status:	Phone Numbers:
☐ Employed Full-time ☐ Employed Part-time ☐ Student ☐ Unemployed ☐ On leave of absence ☐ On disability ☐ Retired ☐ Homemaker	☐ Single ☐ Married ☐ Divorced ☐ Widowed	Home ( ) - Cell ( ) - Other ( ) -

Home Address:

City/State/Zip Code:

Emergency Contact:	Phone:

Employer Name:	Employer Phone:

Physician treating your diabetes:	Phone Number:

Primary Care Physician: (if different than above)	Phone Number:

Protected Health Information: The following persons are allowed access to my protected health information as described below until I revoke permission:

Name: ___________________________________ **Type of information: Medical Financial Both**

Name: ___________________________________ **Type of information: Medical Financial Both**

Revised: 7/25/16

342 S Webster Ave, Green Bay, WI 54301
Phone: 920-435-3002 Fax: 920-884-0201

1818 N Meade St,Ste W245, Appleton, WI 54911
Phone: 920-738-5355 Fax: 920-.882-1891

Office Hours: Monday - Friday 8:30 to 5:00

Financial Policy

Your insurance coverage is based on a contract between you and your insurer.
As part of our service to you:

- We will contact your insurer to determine if the services and devices prescribed by your physician to be provided by us are covered by your insurance policy.
- If your insurer requires prior authorization, we will provide any information we have available to complete this process.
- Our financial department will verify your insurance coverage and attempt to get an estimate of the amount your insurer will pay on your claim. You will be contacted before we begin provision of service to discuss the estimated amount that may be your responsibility. We will not begin working on your device(s) until you give us your verbal consent to proceed and agree to payment of the estimate.
- Payment is due at the time of delivery for any items on the prescription that are not covered by your insurance carrier, or are your part of the deductible, or if you have no insurance coverage.

The estimated amount discussed will be due at the time you receive your device(s). This estimate does not guarantee payment from your insurance company. Any change regarding your insurance coverage that affects your balance after the final decision will be billed or refunded after the final insurance payment is made. We accept cash, checks, and VISA/MasterCard/Discover credit cards.

We will submit claims to primary and secondary insurance carriers. Please remember that your coverage is a contract between you and your insurance carrier. For your convenience, we will handle the submission of claims to your carrier, but we are not a party to your insurance contract. You, the insured, are responsible for payment on any claims that are denied, unpaid due to the deductible, or partially paid.

Assignment of Benefits:

I authorize Monroe BioTechnology Inc to furnish to my insurance carrier(s) any information needed for determination of benefits and payment. I assign benefits to be paid directly to Monroe BioTechnology, Inc on my behalf for services provided. I accept responsibility for any charges not covered by my contract with my insurance carrier.

____________________________________ Signature

______________________ Date