McCook Clinic, P.C.

308.344.4110 • 1401 East H Street

PATIENT REGISTRATION FORM - CC

(Please Print)

Today's Date:			
PATIENT INFORMATION			
Patient's Legal Last Name:	First Name:	Middle Name/Initial:	
Date of Birth:	Social Security Number:	Email:	
Home Phone: ( )	Cell: ( )	Work: ( )	Employer:
Home Mailing Address:	City, State, Zip Code:		
What address should we send your bill to? ☐ Same as Home Mailing Address ☐ Other:			
ADDITIONAL REQUIRED INFORMATION			
Emergency Contact Name:	Phone Number:	Relationship:	
Insurance Subscriber Legal Last Name:	First Name:	Middle Initial:	
Insurance Subscriber Date of Birth:			

****We will also need to take a copy of your insurance card****

Patient Responsibility: I, the undersigned, agree to permit McCook Clinic to render medical services to me. I realize that insurance is considered a method of reimbursing me for fees paid to the doctor, and is not a substitute for payment. I am aware that I may make inquiry of my position relative to fees prior to the date of any professional services required or rendered, or at any time thereafter. That I am aware that late charges may be assessed at 16% annum, commencing 90 days from first statement notification. I agree that I am responsible for payment of said services. I authorize disclosure of patient records to determine liability for payment and/or to obtain reimbursement. I, thereby assign all medical/surgical benefits to which I am entitled to the McCook Clinic, P.C. I understand that I am financially responsible for all charges whether or not paid by said insurance.

CLINIC POLICY IS PAYMENT FOR SERVICES ON THE DAY OF SERVICE.

_____ _____

Signed (patient or parent, if minor) **Date**

For Clinic Use Only

Insurance Updated: ☐ Yes ☐ No