Summit
MEDICAL SPECIALISTS

3821 Vincent Station Dr.
Owensboro, KY 42303
270-478-5334

**OB GYN**

Suzanne Rashidian, DO, FACOOG

**INTERNAL MEDICINE**

Ramin Rashidian, DO, FACOI

**ADVANCED PRACTICE PROVIDERS**

Emily Clark, APRN
Jennifer Meunier, APRN
Madallyn Kirkpatrick PA-C

**AESTHETICS**

Brooke Waninger-White, MA, CLT

# Patient Registration

| | | | | |
|---|---|---|---|---|
| PATIENT NAME: First Last: | | DOB | AGE | CELL PHONE |
| HOME ADDRESS | | CITY | STATE | ZIP CODE |
| OCCUPATION | SOCIAL SECURITY NO. | MARITAL STATUS ☐S ☐M ☐D ☐W | SEX | HOME PHONE |
| EMPLOYER | ADDRESS | | | WORK PHONE |
| SPOUSE (OR PARENT) | SPOUSE (OR PARENT) EMPLOYER | | | SPOUSE (OR PARENT) WORK PHONE |
| PRIMARY CARE PHYSICIAN | ADDRESS | | | TELEPHONE |
| PREFERRED PHARMACY (NAME) | ADDRESS | | | TELEPHONE |
| EMAIL ADDRESS | | | | |

**BILLING AND INSURANCE INFORMATION**

| | | | | |
|---|---|---|---|---|
| PRIMARY INSURANCE | INSURANCE COMPANY NAME | | ID OR POLICY NUMBER | GROUP/CODE |
| | INSURANCE COMPANY ADDRESS | | POLICYHOLDER'S SOCIAL SECURITY | |
| | POLICYHOLDER'S NAME | SEX | HOME PHONE | RELATIONSHIP TO PATIENT |
| | POLICYHOLDER'S ADDRESS | | WORK PHONE | POLICYHOLDER'S DATE OF BIRTH |
| SECONDARY INSURANCE | INSURANCE COMPANY NAME | | ID OR POLICY NUMBER | GROUP/CODE |
| | INSURANCE COMPANY ADDRESS | | | |
| | POLICYHOLDER'S NAME | SEX | POLICYHOLDER'S DATE OF BIRTH | RELATIONSHIP TO PATIENT |

**HOW DID YOU HEAR ABOUT US?**

☐ PHYSICIAN _____
☐ PATIENT/FRIEND
☐ HEALTH FAIR _____
☐ WEBSITE/FACE BOOK
☐ INTERNET _____
☐ MESSENGER-INQUIRER
☐ OWENSBORO PARENT MAGAZINE
☐ BILLBOARDS
☐ NEWCOMERS AD/POSTCARD
☐ LOCAL DIRECTORY/which?_____
☐ OTHER:_____

**BILLING POLICY AND PATIENT AUTHORIZATION**

Payment is required at the time services are rendered and is the responsibility of the patient, parent, or guardian. Unless other arrangements are made, any unpaid balances are due within 30 days of receipt of the invoice. Payment is accepted in the form of cash, check, credit card, or money order.

Cancellation of an appointment with less than 24 hours' notice or any appointment missed without prior notification may be subject to a $50 cancellation charge. After three missed appointments, the scheduling of future appointments will be at the discretion of the practice.

I, the patient named above, hereby authorize Summit Medical Specialists to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company, as referenced above, be made directly to the aboves named provider (or in the case of Medicare Part B benefits, to myself or the party who accepts assignment.)

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either the above-named carrier or me at any time in writing.

I authorize the provider or designated representative to contact me by telephone about appointments, billing, and medical care.

As the patient or parent or guardian, I agree to the above terms and conditions.

_____ _____
Date: Signature of Patient or Guardian: