

# Colorado Mountain Medical, PC (CMM) / Family Registration Form

## RESPONSIBLE PARTY (adult accompanying minor)

Account: \_\_\_\_\_

Full Legal Name: \_\_\_\_\_  
(First Name) (M.I.) (Last Name)

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_ Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F

Cell #: (\_\_\_\_) \_\_\_\_\_ SS #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone \_\_\_\_\_

Local Accommodations; (if visiting or 2nd home owner)

Hotel/Condo Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Room #: \_\_\_\_\_

### Today's Patient (If not responsible party)

Full Legal Name: \_\_\_\_\_  
(First Name) (M.I.) (Last Name)

Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F Account: \_\_\_\_\_

### Other Minor Dependents

Name: _____	Birth: ____/____/____	Sex: M / F	Acct: _____
Name: _____	Birth: ____/____/____	Sex: M / F	Acct: _____
Name: _____	Birth: ____/____/____	Sex: M / F	Acct: _____
Name: _____	Birth: ____/____/____	Sex: M / F	Acct: _____
Name: _____	Birth: ____/____/____	Sex: M / F	Acct: _____

### Parents:

(Mothers Name) \_\_\_\_\_

(Fathers Name) \_\_\_\_\_

### Financial Policy - By signing below, I agree to the following:

1. that I have the authority to authorize CMM to treat the patient
2. that CMM has the authority to obtain any medical records/information needed to treat patient.
3. that CMM may release any and all medical records to secure payment for services rendered.
4. that the responsible party will make immediate payment for services rendered; if CMM is contracted with your insurance company, payment is due immediately on co-pays, non-covered services and co-insurance, and after twenty days on balances due after claim is processed.
5. that if the account becomes past due, a service charge of 1.2% per month will be applied to the account.
6. that failure to cancel a scheduled appointment may result in a cancellation fee.
7. occasionally, a charge may be overlooked and added to your account at a later date. You or your insurance company will be held responsible for missed charges.
8. it is my responsibility to know the patient's insurance plan and covered benefits.
9. that I consent to the procedures, which may be performed during the office visit.
10. I authorize payment of medical benefits to CMM for services rendered. I also understand that I am financially responsible to CMM for charges not covered by my insurance carrier.

### Acknowledgement of Receipt of notice of Privacy Practices for Colorado Mountain Medical, PC

I hereby acknowledge that I have received and/or reviewed a copy of CMM's **Notice of Privacy Practices**.

### Yes/No (circle)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### Relationship:

- Parent or guardian of minor patient
- Guardian of minor patient
- Representative of deceased patient

### For Office Use Only:

- Signed form received by: \_\_\_\_\_
- Acknowledgement refused: \_\_\_\_\_
- Efforts to obtain: \_\_\_\_\_
- Reasons for refusal: \_\_\_\_\_