AID Upstate

PATIENT REGISTRATION

Legal Name: (Last, First, Middle)	Preferred Name:	Date of Birth:

Sex assigned at birth: _____Female _____Male
Pronouns:_____

Social Security Number:

*While we recognize all genders/identities; many insurance companies and legal entities unfortunately do not. Please be aware that your legal name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence.

Home Address: (City/ State/ Zip)

Email Address:	Home Phone #:	Cell Phone #:

Emergency Contact:	Relationship:	Emergency Phone:

Marital Status: _____Married _____Partnered _____Single _____Divorced _____Other

Ethnicity:	Race:	Preferred Language:
_____ Hispanic/Latino _____Not Hispanic/Latino	_____Caucasian _____African American _____ Asian _____American Indian _____Other	

Insurance Information:

CONSENT TO TREAT, BENEFIT ASSIGNMENT, AND FINANCIAL POLICY

I consent to medical care and treatment as ordered by a licensed Healthcare Provider and certify that the insurance information listed above is correct. I hereby authorize the release of all information necessary to secure payment of benefits.

AID Upstate participates in the Electronic Health Exchange. This allows patients records to be shared with other participating hospitals and medical practices such as AnMed, Prisma Health System (formally Greenville Health System) and Bon Secours Health System. Your information is not shared without you having an appointment at one of these facilities.

Payment is due at the time services are rendered unless specific arrangements have been made prior to treatment. Our network does participate with a number of insurance plans. Please contact your insurance company to verify participation. If we participate with your insurance carrier, you will be expected to pay your portion of the charge and/or a predetermined copayment on the date of service. We will file your insurance claim. If you are not covered by an insurance plan or sliding fee, payment in full will be expected at the time of service. If this creates a financial hardship for you please inform the receptionist.

_____ _____ _____

Signature of Patient or Legal Guardian | Printed Name of Patient or Legal Guardian | Date