REGISTRATION • AUTHORIZATION

472 Chalan San Antonio • Tamuning • Guam • 96913 • P: 647-1830 • F: 647-1919 • marianasphysiciansgroup@saguamanagu-mpg.com

PERSONAL INFORMATION

PATIENT'S LAST NAME	FIRST NAME	MIDDLE NAME	SOCIAL SECURITY NUMBER
PATIENT'S MAILING ADDRESS			NAME OF PRIMARY PHYSICIAN
RESIDENTIAL ADDRESS, if different from mailing			CONTACT INFORMATION Home________ Cell________ Email ________
DATE OF BIRTH MM/DD/YY	AGE (YEARS):	SEX: ❑ Female ❑ Male	BIRTH PLACE
OCCUPATION (TITLE)	EMPLOYER	WORK PHONE NUMBER	CONTACT PREFERENCE (Check one) ❒Home ❒Work ❒Cell ❒Email
HAVE YOU EVER BEEN A PATIENT AT THIS CLINIC? YES ( ) NO ( ) IF YES, APPROXIMATE DATE			

NAME OF SPOUSE or GUARANTOR other than patient			SOCIAL SECURITY NUMBER
MAILING ADDRESS			RELATIONSHIP TO PATIENT
RESIDENTIAL ADDRESS, if different from mailing			CONTACT NUMBER(S) Home________ Cell________ Email ________
DATE OF BIRTH MM/DD/YY	AGE (YEARS):	SEX: ❑ Female ❑ Male	BIRTH PLACE
OCCUPATION (TITLE)	EMPLOYER	WORK PHONE NUMBER	CONTACT PREFERENCE (Check one) ❒Home ❒Work ❒Cell ❒Email

NOTIFY IN CASE OF EMERGENCY other than spouse	RELATIONSHIP TO PATIENT	CONTACT NUMBER(S)
MAILING ADDRESS, if different from patient	RESIDENTIAL ADDRESS, if different from mailing	

INSURANCE INFORMATION

NAME OF INSURANCE (Primary)	POLICY NUMBER (Primary)	EFFECTIVE DATE:
NAME OF INSURANCE (Secondary)	POLICY NUMBER (Secondary)	EFFECTIVE DATE:
NAME OF POLICY HOLDER if different from patient	RELATIONSHIP TO PATIENT	CONTACT NUMBERS
EMPLOYER OF POLICY HOLDER & ADDRESS		ARE YOU ENTITLED TO MEDICAID OR MIP? YES ( ) NO ( )

AUTHORIZATION & CERTIFICATION

Payment and Assignment of Insurance Benefits: I authorize Marianas Physician's Group(MPG) to request payment for covered services rendered by my Insurance Company and/or Medicare/Medicaid/Medically Indigent Program and that payment be made directly to Annie U. Bordallo, MD/Marianas Physicians Group or if necessary to apply to same for benefits on my behalf. I also authorize MPG to give any necessary information from my medical records for payment purposes to my insurance carrier or billing agent. If the insurance company has not paid within 60 days of billing, payment is due in full from the patient. All patients on public assistance must provide current and valid documentation of coverage before being seen.

Medical Treatment: I authorize MPG and covering providers to administer such medical examinations, diagnostic procedures and treatments that in their judgment may be advisable for my wellbeing. I have read and fully understand this authorization for medical treatment. I further certify that no guarantee has been made as to the result that may be obtained.

Appointments: I understand that it is the patient's responsibility to remember her appointments. MPG staff will use health and contact information provided to send or call you with appointment reminders as a courtesy. If the appointment is not confirmed 48 hours prior to the appointment time, MPG reserves the right to allot the time slot for another patient.
Should you wish to make any changes to your appointment schedule, you may call the clinic at 647-1830 24 hours or more before your scheduled appointment. **A fee of $25.00 will be charged for all missed appointments without a 24-hour notice.**

Financial Responsibility: I understand that payment is expected at the time of service. I agree to pay my share of the fees and cost for services rendered. I am also responsible for any and all additional fees; cost and penalties, including pre-collection and post-collection expenses and interest that MPG or its authorized representatives may assess if I fail to meet the terms of my financial obligation. I am aware that I may contact a MPG Billing Representative at 647-1818 or 647-1819 if I have any questions regarding the fees or if I wish to make payment arrangements. Cash, checks and most major credit cards are accepted.

Additional Fees: A fee of $50.00 will be assessed for all returned checks.

Certification: I certify that I have read the foregoing and I am the patient or authorized patient representative and/or I am duly authorized as the patient's guarantor to execute the above and accept its terms. Additionally, I certify that the information I have reported on this form is correct and true. A copy of this authorization and certification may be used in place of the original and may be revoked by the patient or authorized representative at any time in writing.

______________________	______________________	______________________
Signature of Patient or Authorized Representative	Signature of Guarantor or Responsible Party	Witness
______________________	______________________	______________________
Date	Date	Date