Pear Tree
MEDICAL ASSOCIATES

Patient Registration Form

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email address: _____

Sex: ☐ Male/ ☐ Female **Date of Birth: _____ Age: _____ Marital Status: _____**

Race/Ethnicity: _____ Primary language: _____

Employer Name: _____ Occupation: _____

Name of Spouse: _____ His/Her Employer Name: _____

Emergency Contact: _____ Relation: _____

Emergency Contact Phone Number: _____

Primary Insurance Holder:_____Date of Birth:_____

PrimaryIns:_____ID/Subscriber #_____Group #_____

Secondary Ins:_____ID/Subscriber #_____Group #_____

Pharmacy Name: _____

Address/Location_____Phone:_____

Patient Signature:_____Date:_____

6302 Broadway, Suite 130
Pearland, TX 77581
www.peartreemedical.com
Phone: 281-412-6700

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Financial Policy

PAYMENT RESPONSIBILITY

Payment for all services is the responsibility of the patient. As a courtesy to all our patients, Pear Tree Medical Associates will file a claim with your insurance company. However, this is not a guarantee of payment; therefore, it is important for you to be aware of your insurance coverage and limitations. Ultimately, financial responsibility for services rendered rests with the patient or his/her family regardless of the nature or extent of insurance coverage. The patient is further responsible for co-payments, deductibles, co-insurance and any balance remaining after receipt of insurance payment.

CANCELLATION AND MISSED APPOINTMENTS

Our goal is to provide quality medical care in a timely and professional manner. In order to accomplish this, we have a cancellation and missed appointment policy. This policy enables us to more efficiently utilized our resources to better serve our patients, provide you with the very best medical care, and accommodate most appointment requests.

As all medical services are provided by appointment only and that time is reserved for your exclusive use, we request 24 hours notice via phone call to 281-412-6700 to cancel an appointment.

There is a fee of $25 for missed appointments and/or cancellations made less than 24 hours in advance.

PAYMENT OPTIONS

Pear Tree Medical Associates offers the following payment options:

1. Payment in full on the day the service is provided
2. Payment of co-payment, co-insurance or deductible on the day service is provided
3. Payment of co-insurance, deductible or amount denied by insurance upon receipt of statement.

For your convenience, Pear Tree Medical Associates accepts cash, MasterCard, VISA or Discovery Cards. If additional financial counseling is needed please contact the Business Office at 281-412-6700

I have read, understand, and agree to the financial policy as stated above. I hereby authorize payment of medical benefits to Pear Tree Medical Associates for any service furnished me by that provider. I authorize physician and clinic to release any information to process insurance claims. This authorization is in effect indefinitely unless revoked in writing.

Patient Signature:_____ Date:_____

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