Melanie Conway, M.D.
1405 North Pierce, Suite 212
Little Rock, AR 72207

Registration Form

(All blanks must be completed; mail completed forms to above address.
Dr. Conway will call with appointment when completed forms received)

Patient Information

Patient's Last Name First Middle Marital Status ___Mr. ___Miss ___Single ___Mrs. ___Ms. ___Mar ___Wid ___ Dr. ___Div ___Sep

Birth date Home Tel Mobile Tel Work Tel ___Male

/ / ___Female

May I call this number? ___Yes ___No ___Yes ___No ___Yes ___No
May I leave a message? ___Yes ___No ___Yes ___No ___Yes ___No

Street Address City State Zip Code E-Mail Address

Do I have permission to contact you at the above address?___Yes ____No E-mail address? ___Yes___No

Emergency Contact Name a Local Friend or Relative May I call her/him? Relationship to Patient

Street Address City State Zip Code Telephone

Financial Responsibility

Last Name First Middle Relationship to Patient

Address City State Zip Code Telephone
May I call him/her?
_____Yes _____No

Visa/MC # (required) Expiration Date Security code Signature

PLEASE READ CAREFULLY THE FOLLOWING PARAGRAPHS:

I consent to treatment for the above named patient.

I acknowledge full financial responsibility for services rendered by Melanie Conway, M.D., and authorize transfer of all unpaid amounts to my Visa/MC.

I understand that the payment of charges incurred is due at the time of service. New patient appointments are $350 and follow-ups are $105 and $160.

I understand that Melanie Conway, M.D. is a non-participating provider-that is, a physician non-affiliated with a commercial insurance plan or government plan (Medicare/Medicaid). I also understand that it is my responsibility to contact the insurance company in order to determine my out of network benefits and if required, obtain precertification prior to seeing the doctor, and I assume full responsibility for any financial loss resulted from denial of non-authorized or non-covered services.

I understand that Dr. Conway does not bill insurance on my behalf, but a receipt for services will be presented to me at the time of service so I may bill my insurance company personally.

CANCELLATIONS AND MISSED APPOINTMENTS POLICY:

Cancellations and Missed Appointments: Please be advised that a charge equal to the fee for the session will be assessed for appointments cancelled without 24 hours notice or missed appointments.

Patient/Guardian Signature **Date**