

REGISTRATION FORM

PLEASE USE CAPITAL LETTERS!

Last/Family Name		First/Given Name	
Date of birth (DD/MM/YY) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		Nationality:	
Gender (please circle one) MALE / FEMALE		Home Telephone:	
Insurance Provider:		Expiry date:	
Insurance Policy No.:		Insurance ID No.:	
TAJ-Hung. Social Sec. Number:		Mobile:	
E-mail:		Work Telephone:	
Are you....	<input type="checkbox"/> living in Hungary?	<input type="checkbox"/> a visitor/tourist?	<input type="checkbox"/> student?
		<input type="checkbox"/> missionary?	<input type="checkbox"/> Other?:

ADDRESS IN HUNGARY

c/o (Name on mailbox/ door/ hotel's name)	Street	Number	Floor/Door
City	Postal Code	Is this your permanent address? <input type="checkbox"/> Yes <input type="checkbox"/> No	

PERMANENT ADDRESS (IF DIFFERENT FROM THE ABOVE ONE)

c/o (Name on mailbox/ door/ hotel's name)	Street	Number	Floor/Door
City	Postal Code	Country	

ADDRESS ON INVOICE (IF DIFFERENT FROM THE PERMANENT ADDRESS)

c/o	Street	Number	Floor/Door
City	Postal Code	Country	
Employer's / Company Name:		Is this your employer's address? <input type="checkbox"/> Yes <input type="checkbox"/> No	

EMERGENCY CONTACT / PARENT OR GUARDIAN

First Name	Last Name	Telephone:
The relationship: <input type="checkbox"/> Guardian <input type="checkbox"/> Family:..... <input type="checkbox"/> Friend <input type="checkbox"/> Colleague <input type="checkbox"/> Other:.....		

How did you hear about the clinic? (Please tick and specify!)

Advertisement: <input type="checkbox"/>	Relocation company: <input type="checkbox"/>	Word of mouth / Friend / Co-worker
Internet / Website: <input type="checkbox"/>	Embassy: <input type="checkbox"/>	Other:

DEPENDENTS

	Last Name	First Name	Gender	Date of birth (DD/MM/YY)	Telephone
1.			M / F	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	
2.			M / F	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	
3.			M / F	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	
4.			M / F	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	
5.			M / F	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	

By giving the correct information, you help us to provide you with a better service in the future.

If you have any questions, please do not hesitate to contact the reception!

Please turn over →



AGREEMENT OF SERVICES

Thank you for choosing FirstMed Centers Kft. as your healthcare provider. We are committed to providing you with the highest quality medical care and service. In order to avoid any misunderstanding, we ask that you read the following payment policy, ask us any questions you may have, and sign in the space provided.

Payment is due at the time of service unless other arrangements have been made with the Clinic. We accept Hungarian Forint or most major credit cards. (Visa, MasterCard, AmericanExpress, Maestro, Eurocard).

Insurance: We direct-bill to a number of international insurance companies. If this is applicable to you then we require a credit card guarantee form to be filled in. Any deductibles and/or co-pays required by the insurance company need to be paid at the time of service. Please contact your insurance company with any questions you may have regarding your coverage. In case you are not able to give us a credit card guarantee or you have an insurance which is not eligible for the direct billing at the FirstMed, we require payment at time of service.

Claims submission: We will submit claims and assist in any way we reasonably can to help obtain payment for insurance claims. Occasionally, insurance companies may need additional information and/or patient verification of services in order to pay the claim. It is the patient's responsibility to comply with their request. All balances are the patient's responsibility in the event an insurance company for any reason denies a claim.

Co-payments and deductibles: All co-payments and deductibles must be paid by the patient or guardian at time of service. This arrangement is part of the contract with an insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.

Missed appointments: Our policy is to charge for missed appointments not canceled within 24 hours before the scheduled time. These charges will be the patient's (or Guardian's) responsibility and will be billed directly. Please help us to serve you better by keeping your regularly scheduled appointments. In case the patient is late more than 10 minutes, we cannot always guarantee the scheduled appointments.

On behalf of myself and my dependents, I have read the above information and have received the current price list for FirstMed. I understand that payment is due at the time the services are rendered and I have the right to ask questions related to the costs of any test(s) or procedure(s) before being administered.

Signature

Date

Print Name

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS FORM!