Axelix Health Consulting, Inc.
Olusegun Ogunlesi, MD
38033 Euclid Avenue, Suite T8
Willoughby, Ohio 44094

AHCI AXELIX HEALTH CONSULTING, INC.

Patient Registration Form

Patient Name: ____ Social Security Number: ________-_______-________

Date of Birth: _______/______/_______ Sex: M __ F __ Marital Status: Married __ Single __ Divorced __ Widowed __

Address: ____
(Street) (City/State/Zip)

Home Phone: (______)___________________________ Cell Phone: (______)___________________________

Employer Name: __________________________________ Employer Phone Number: (______)___________________________

Address: ____
(Street) (City/State/Zip)

Primary Care Physician: _____________________________________ Phone Number: (______)___________________________

Referring Physician: ____ Phone Number: (______)___________________________

Person responsible for the bill or parent (Complete only if different from patient)

Guarantor Name: ____ Social Security Number: ________-________-________

Relationship to Patient: ____ Date of Birth: ________/_______/_________

Address: ____
(Street) (City/State/Zip)

Employer Name: ____ Employer Phone: (______)___________________________

Emergency Contact

Name: ____ Relationship: _____________________________________

Home Phone: (______)___________________________ Cell Phone: (______)___________________________

Address: ____
(Street) (City/State/Zip)

Primary Insurance Information

Plan Name: ____ I.D. Number: ______________________________________

Address: ____ Group Number: _____________________________________

Policy Holder: ____ Effective Date: ________/_______/_________

Policy Holder's Social Security Number: ________-________-________

Policy Holder's Date of Birth: _________/_________/_________ Sex: M __ F __

Secondary Insurance Information

Plan Name: ____ I.D. Number: ______________________________________

Address: ____ Group Number: _____________________________________

Policy Holder: ____ Effective Date: ________/_______/_________

Policy Holder's Social Security Number: ________-________-________

Policy Holder's Date of Birth: _________/_________/_________ Sex: M __ F __

I hereby authorize Axelix Health Consulting, Inc., to furnish information to insurance companies as may be requested for illness or injury. This authorization shall apply to my records or any minor listed either above or below.

Signature of Responsible Party: ____ Date: ________/_______/_________

Printed Name (if not the patient): ____

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Government regulations require we ask the following identifying information:

Race: *__ Caucasian* *__ African American* *__ Hispanic* *__ Russian* *Other* ___________________________

Ethnicity: *__ Non-Hispanic* *__ Hispanic*

Primary/Preferred Language: *__ English* *__ Spanish* *Other* ____

Preferred Pharmacy: ____

Pharmacy Address: ____________________________ **City/State:** _____________________ **Zip:** _____________

Phone number: (______)____________________________ **Fax number:** (______)____________________________

By signing below I authorize *Axelix Health Consulting, Inc.,* to access pharmacy data electronically through RXHub to determine drug formulary and obtain a historic list of medications.

Signature: ____ **Date:** ________/_______/_________

Patient Portal

Is a new tool that enables *Axelix Health Consulting, Inc.* to communicate with patients in a new and secured format. Patient portal can be accessible from anywhere with internet access. With Patient Portal, you will have access to

- **Appointments:** Setting up appointments' appointment reminder
- **Lab results:** Receive and view latest lab results
- **Medications:** Prescription refill request
- **Medical Records:** Access to electronic medical records etc.
- **Education:** Receive educational material
- **Messages:** Send messages to clinical staff
- **Billing:** View statements and pay bills online

If interested, provide your email address below in a legible format. Thank You.

Email address: ____

OR

If you are not interested in participating in Patient Portal

Patient Signature: ____ **Date:** ________/_______/_________

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STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Patient Name: ____ DOB: _______/______/_______

Axelix Health Consulting, Inc., appreciates the confidence you have shown in choosing us to provide for your healthcare needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

I authorize my insurer to pay any benefits directly to ***Axelix Health Consulting/Dr. Ogunlesi***, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

You are responsible for payment of any deductible and copayment/coinsurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full. ***A $40 return check fee will be billed to the patient for each returned check in addition to the unpaid amount.***

CO-PAY POLICY

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patient to pay at ***EACH VISIT***. Thank you for your cooperation in this matter.

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Olusegun Ogunlesi through his appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Dr. Olusegun Ogunlesi/Axelix Health Consulting, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

CANCELLATION/NO SHOW POLICY

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to **call 24-hours prior** to cancel your appointment. I understand if I am a "***No Show***" for two or three consecutive appointments, or cancel for a total of three appointments, I may be discharged from care and **charged $20** for each "***No Show***" visit. The practice will notify you in writing, via certified mail, if you are discharged from care. I have read and understand the above information, and I agree to the terms described.

I have read the above policy regarding my financial responsibility to Dr. Ogunlesi/Axelix Health Consulting, for providing rehabilitative services to me or the above named patient.

Patient Signature: ____ Date: ________/_______/_________

Guarantor Signature: ____ Date: ________/_______/_________

(If guarantor is not the patient)