Axelix Health Consulting, Inc.
Olusegun Ogunlesi, MD
8587 East Avenue
Mentor, OH 44060-4301

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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AXELIX HEALTH CONSULTING, INC.
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)