

Pre-Registration Form

PATIENT INFORMATION

Date of Visit ----- Doctor -----

Last Name ----- First Name ----- Middle Initial -----

Street ----- State ----- City -----

Home Phone ----- Work Phone ----- Cell Phone -----

SSN# ----- Birth Date ----- Sex -----

Responsible Party (if patient is a minor)

Last Name ----- First Name ----- Relationship -----

Street ----- State ----- City -----

Employer ----- Occupation ----- Marital Status -----

Employer Address Street ----- State ----- City -----

Primary Physician ----- Referred By -----

Emergency Contact Person ----- Phone Number -----

INSURANCE INFORMATION

Primary Insurance

Primary Insurance ----- Identification # ----- Group # -----

Employer of Policy Holder ----- Policy Holder ----- Relationship to Patient -----

Policy Holder SSN -----

Birth Date ----- Effective Date -----

Secondary Insurance

Secondary Insurance ----- Identification # ----- Group # -----

Employer of Policy Holder ----- Policy Holder ----- Relationship to Patient -----

Policy Holder SSN -----

Birth Date ----- Effective Date -----

ASSIGNMENT & RELEASE

I hereby authorize payment of benefits be made directly to _____ for services rendered to myself and/or dependents. I understand that I am responsible for any charges not paid by insurance. I authorize the release of any medical & billing information to my insurance company and the billing party named on behalf of me and/or my dependents. I permit a copy of this authorization to be used in place of the original.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare Benefits be made on my behalf to _____ for any services furnished by my physician. I authorize any holder of medical information about me to release to Medicare & its agents any information needed to determine these benefits or the benefits payable for related services. I understand my acceptance requests that payment be made & authorizes release of medical information necessary to pay the claim. If other health insurance is indicated on the approved claim form or electronically submitted claims, my acceptance authorizes releasing the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and I am responsible only for the deductible, coinsurance, and non-covered services of this charge.

WRITTEN ACKNOWLEDGEMENT

I acknowledge the receipt of the [Notice of Privacy Practices](#) _____ for _____, which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

USER AND/OR DISCLOSURE

I understand that under the HIPAA regulations, my health information will be used and disclosed to any health care provider who is involved with my medical treatment or services, my health insurance plan, and any medical clearinghouse who is involved with your insurance claims fulfillment.

Under these new regulations the following people must be authorized by you to have access to your health information: your spouse; other family members and friends; nurse or home aid; legal guardian; or other person/organization who is not involved with your medical treatment, insurance plan or payment.