REGISTRATION FORM

Please Print

Date: ____________________ Phone: ___________________ Email: ____________________

Name: ____
Last First Middle Int.

Street Address: ____

City: ______________________________ State: __________ Zip: ____________

DOB: __________________ Sex: ( )M ( )F Marital Status: ( )Single ( )Married ( ) Other

Employer's Name: ____

Primary Insurance Information:

Primary Insurance Plan: ____

Insured's ID Number: _________________________ Group Number: _______________________

Complete Information below if different from client information:

Insured's Name: ____
Last First Middle Int.

Street Address: ____

City: ______________________________ State: ____________ Zip: ____________

Phone: ___________________________ DOB: _________________ Sex: ( )M ( )F

Employer's Name: ____

Secondary Insurance Information:

Secondary Insurance Plan: ____

Insured's ID Number: _________________________ Group Number: _______________________

Complete Information below if different from client information:

Insured's Name: ____
Last First Middle Int.

Street Address: ____

City: ______________________________ State: ____________ Zip: ____________

Phone: ___________________________ DOB: _________________ Sex: ( )M ( )F

Employer's Name: ____

Assignment and Release

I, the undersigned, have insurance coverage with ____
(Name of Insurance Company)
and assign directly to _______________________________________ all medical benefits, if any,
(Name of Clinician)
otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize __________________________________
(Name of Clinician)
to release all information necessary to securethe payment of benefits. I authorize use of this signature on all my insurance submissions.

____
(Signature) (Date)

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to
____ for any services furnished me by
(Name of Clinician)
the above named clinician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "Other Health Insurance" is indicated on the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases,
____ agrees to accept the charge
(Name of Clinician)
of the Medicare carrier as the full charge and the patient is responsible only for the deductible coinsurance and non-covered services. Coinsurance and deductible are based on the charge determination of the Medicare carrier.

____
(Signature) (Date)

PLEASE ATTACH COPIES OF ALL INSURANCE CARDS