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PATIENT REGISTRATION

(PLEASE PRINT)

Today's Date:_____

Patients full name:_____Preferred Name:_____

Date of birth:_____Age:_____

Home Adress:_____City:_____State:_____Zip:_____

Home Phone:_____Email:_____

Cell Phone:_____Birth Sex:_____

Gender Identity: (circle one or skip if prefer not to answer) Male, Female, Transgender Male(FTM), Transgender Female(MTF), Gender Fluid(neither exclusively MorF), Choose not to disclose **Sexual Orientation**: (circle one or skip if prefer not to answer) Heterosexual, Lesbian, Gay, Bisexual, Unknown, Other, Choose not to disclose

Patient or Parent/Guardian's employer:_____Phone #:_____

If Student, Grade:_____School:_____

Family Physician:_____Physician's phone #:_____Referred by:_____

Person to contact in an emergency:_____Phone #:_____

INSURED/RESPONSIBLE PERSONS INFORMATION

Please complete this section regardless of insurance coverage

Full Name of Responsible person_____Birthday:_____Relationship:_____

Home Address:(Same as above ___)_____City:_____State:_____Zip:_____

Employer:_____Phone#:_____

Insured's/Responsible person SS#_____

Insured's Primary Ins. Co._____ID#:_____Group#:_____

Secondary Ins. Co._____ID#:_____Group#:_____

OFFICE BILLING AND INSURANCE POLICY

1. I authorize use of this form for all my insurance submissions.
2. I authorize at the release of information to insurance company(s).
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I authorize direct payment to my service provider.
5. I hereby permit a copy of this to be used in place of an original.

Signature:_____Date:_____

- It is your responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by your insurance the day and time service is provided. Cash/ credit cards are the only accepted forms of payment.
- There is a 24 hour cancellation policy. You must cancel your appointment 24 hours in advance, between the hours of 8am and 8pm Monday through Friday. If not, then it is counted as a "no show" appointment. After 3 "no show" appointments, I reserve the right to terminate. There is a $50 charge for cancellations less than 24 hours. By signing you agree to this policy.

Signature:_____Date:_____