REGISTRATION FORM

NAME _____
LAST FIRST MIDDLE INITIAL

STREET_____

CITY_____ STATE_____ ZIP CODE_____

REFERRING DOCTOR /PCP_____

HOME PHONE _____ JOB PHONE_____

BIRTH DATE_____ SS # _____ SEX_____ M_____ F_____

MARITAL STATUS MARRIED_____ SINGLE_____ DIVORCED_____ WIDOWED_____

PRIMARY INSURANCE COMPANY_____

POLICY #_____ GROUP #_____

PATIENT RELATIONSHIP TO INSURED? SELF_____ SPOUSE_____ CHILD_____ OTHER_____

SUBSCRIBER NAME, IF NOT THE SAME_____DATE OF BIRTH_____

SECONDARY INSURANCE COMPANY_____

POLICY # _____ GROUP # _____

PATIENT RELATIONSHIP TO INSURED? SELF_____ SPOUSE_____ CHILD_____ OTHER_____

SUBSCRIBER NAME, IF NOT THE SAME_____DATE OF BIRTH_____

VERIFICATION OF BENEFITS INFORMATION

Covered Benefit: DX Code _____
97802, 97803, 99404
Number of visits covered: Deductible information: in network deductible?

Preventive Benefit:

Representative name:

Date of verification of coverage

Reference # for call

I AUTHORIZE ANY HOLDER OF MEDICAL OR ANY OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND THE CENTERS FOR MEDICARE AND MEDICAID SERVICES OR its INTERMEDIARIES OR CARRIERS, OR TO THE BILLING AGENT OF THIS PROVIDER, ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICAL CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

IF YOUR INSURANCE COMPANY FAILS TO PAY FOR SERVICES, YOU WILL BE RESPONSIBLE.FOR PAYMENT

SIGNED_____ **DATE**_____