

Patient Registration

(PLEASE PRINT CLEARLY!)

Patient's Name: _____ SS #: _____
First Name MI Last Name

Date of Birth: _____ __Male __Female __Single __Married __Widowed __Divorced __Separated

Street Address : _____

City/State/Zip Code: _____ Home Phone w/Area Code: _____

Cell Phone w/Area Code: _____ Fax w/Area Code: _____

e-mail Address: _____ Can this be used for communicating with you? Yes__ No__

Spouse's Name: _____ SS #: _____

Spouse's Employer: _____ Spouse's Work Phone #: _____

Patient's Employer: _____ Work Phone w/Area Code: _____

Responsible Party: _____ Relationship: __Self __Spouse __Parent __Other: _____

If patient is a Minor, are parents __Married __Divorced Custodial Parent: _____

Custodial Parent's Home Phone w/Area Code: _____ Work Phone w/Area Code: _____

In case of emergency, contact (not living with you): _____

Phone Number w/Area Code: _____ Relationship to Patient: _____

Is this work-related? __Yes __No If yes, date of injury? _____ Claim #: _____

Is this auto accident related? __Yes __No If yes, date of injury? _____ Claims# _____

Insurance Company to be billed _____

Adjuster's Name & Phone # _____

Attorney's Name & Phone # _____

Referring Physician's Name & Phone Number: _____

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFORMATION

Insurance Company # 1: _____ Phone Number: _____

>>Primary Insured's Name: _____ >>Date of Birth: _____

Policy #: _____ Group #: _____ Relationship: _____

Address: _____

Insurance Company # 2: _____ Phone Number: _____

>>Primary Insured's Name: _____ >>Date of Birth: _____

Policy #: _____ Group #: _____ Relationship: _____

Address: _____

- I hereby authorize the payment of medical benefits to Active Life Acupuncture, LLC for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier. I permit a copy of this authorization to be used in place of the original.
- I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.
- I hereby authorize Active Life Acupuncture, LLC to release any medical information necessary to complete and process my insurance claims.

>> _____ Date
>>Patient's OR Insured's Signature (If patient is a Minor, must have Responsible Party Signature)

I authorize Active Life Acupuncture, LLC to treat me and use my personal health information for healthcare operations.

>> _____ Date
>>Patient's Signature (OR Parent if patient is a Minor)

Billing Policy & Acknowledgement of HIPAA Privacy Policy

The following sets forth the general billing policy of Active Life Acupuncture, LLC. Please review this information and sign where indicated.

- ❖ I understand that it is my responsibility to provide the office of Active Life Acupuncture, LLC accurate billing information at the time of check in and to notify the provider of any changes in this information.
- ❖ I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that the provider also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.
- ❖ I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a \$25 NSF fee. I further understand that to rectify my account, I will be required to pay with either cash, a money order, cashier's check, or credit card.
- ❖ I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/ deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.
- ❖ I understand that the provider will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.
- ❖ I have received a copy of the Notice of Privacy Practices as required by HIPAA from Active Life Acupuncture, LLC and understand my rights with regard to my personal health information disclosure.

My signature below confirms that I have read and understand these billing policies, privacy practices and my financial obligation as pertains to the health care provider, Active Life Acupuncture, LLC.

Patient's Signature

Date

Legal Guardian to Patient (if patient is minor or incapable of signing)