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 #____

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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 Kathleen Fraser, L.Ac., 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 Kathleen Fraser, L.Ac. to release any medical information necessary to complete and process my insurance claims.

>>____ ____________________

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

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I authorize _____________. to treat me and use my personal health information for healthcare operations.

>>____ ____________________

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

Billing Policy & Acknowledgement of HIPAA Privacy Policy

The following sets forth the general billing policy of **Kathleen Fraser, L.Ac**. Please review this information and sign where indicated.

- I understand that it is my responsibility to provide the office of **Kathleen Fraser, L.Ac**., 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 **Kathleen Fraser, L.Ac**., 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 pertain to the health care provider, **Kathleen Fraser, L.Ac.**

____ ____________________

Patient's Signature Date

____

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