

PATIENT REGISTRATION
(Please Print All Information Clearly)

Patient's Name _____ Age ____ Date of Birth ____/____/____

Address _____ City _____ State ____ Zip _____

Home Phone _____ Work _____ ext _____ Cell _____

E-Mail Address _____ Social Security# _____

Employer _____ Occupation _____

Emergency Contact _____ Relationship _____ Phone _____

Name of Health Insurance _____ Phone# _____

Address to Send Claims _____

Primary Insured's Full Name _____ DOB ____ Spouse/Parent(circle)

Insured's ID# _____ Group# _____

How did you hear about us? _____

This visit is a result of: [] auto accident [] work accident [] sports injury [] home injury [] other
Reason for this visit: _____

*****FEMALE ONLY*****

Are you pregnant? []yes []no []maybe How far along? _____

PLEASE NOTE: Basic responsibility for all professional services belong to the patient.
This office will assist you in preparing forms and billing.

I understand that I am financially responsible for all charges whether or not paid by any third party. I agree that all charges are payable and collectible in this county. I hereby authorize Heidi Barlin, L.Ac. to make inquiries, endorse drafts and to release any information to my insurance company, employer, attorney, or benefit plan about my case. I furthermore irrevocably authorize and direct any of these agents to pay what is due for professional services directly to Heidi Barlin, L.Ac.

PRIVACY: I consent to the use and disclosure of my protected health information for the purpose of providing treatment to me, for purposes relating to the payment of services and for the Practice's general healthcare operations purposes. I understand that I have the right to review the Practice's Notice of Privacy Practices prior to signing this document. I understand that I have the right to request restriction on the use and disclosure of my Protected Health Information.

Your appointment time is reserved specifically for you. In the event of a missed appointment or an appointment cancelled with less than 24 hours notice you may be charged a \$35 fee. Insurance will not pay for a missed appointment.

Please indicate your understanding and acceptance of these policies by signing below.

Signature Printed Name Date