PATIENT REGISTRATION

Name Last _____ First _____ MI ____ Birth Date _____

Address _____ City _____

State _____ Zip _____ Circle One Male Female

Home #_____ Cell #_____ Work #_____

Policy Holder Name _____ Policy Holder Birth Date _____

Spouse's Name & Phone # _____ Spouse's Birth Date _____

Emergency Contact _____ Relationship _____ Phone _____

If Patient is a Minor – Name of Responsible Person _____

Relationship to minor _____ Phone #1_____Phone #2 _____

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WRITTEN ACKNOWLEDGMENT FORM

I acknowledge that Progressive Medical Clinic has provided me a written copy of the Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask any questions.

We <u>will</u> leave test results on your answering machine <u>UNLESS</u> you specifically request that we do not leave a message on your answering machine regarding test results. ***If you do not*** want us to leave a message on your answering machine, it will be your responsibility to make an appointment 1 week after the test is performed to discuss results.

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Patient Signature **Date** **Representative Signature (if applicable)** **Relationship to Patient**

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INSURANCE PAYMENT POLICY and PATIENT'S RESPONSIBILITY

I authorize direct payment of my insurance benefits to Progressive Medical Clinic for services rendered to myself or my dependents. I understand I am responsible for any co- pay or balance due that is determined by my insurance carrier for any reason. I understand it is my responsibility to know my insurance benefits and whether or not the services I am to receive are covered benefits.

I authorize the release of any information that may be necessary for medical evaluation, treatment, consultation or processing of insurance benefits. I hereby consent to evaluation, testing and treatment as directed by Progressive Medical Clinic.

AGREEMENT: I have reviewed above document today and agree to its terms and conditions for treatment.

Patient Signature _____ Date _____