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 _____

****

WRITTEN ACKNOWLEDGMENT FORM

I acknowledge that Progressive Medical Clinic has provided me with 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 to ask any questions.

We will leave test results on your answering machine **UNLESS** you specifically request that we do not.

*I understand that I am responsible for contacting the office to request my test results if I do not receive them **two weeks** after any tests that are ordered or completed here.*

_____

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

****

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 _____