Patient Registration Form

Patient Name:______________________________ Social Security Number: _____-______-______
Date of Birth: ____/_____/_____ Sex: Male / Female
Address: ____
(Street) (City/State/Zip)
Home Phone: (____) ______-__________ E-Mail Address: ______________________________
Would you be interested in having communications sent to you via your e-mail address? (Examples: Appointment reminders, administrative updates, and health bulletins)
Cell Phone: __________________________ Employer Phone Number: (____) ______-_______
Primary Care Physician: ___________________________________ Copay Amount $___________
(Name)
How did you hear about our practice? ____

Person responsible for bill or parent (Complete only if different from patient)
Guarantor Name: ________________________________ Social Security Number: _____-____-_____
Relationship to Patient: (please check): ( )Self, ( ) Spouse, or ( ) Parent Date of Birth: ___-___-_____
Address: ____ Phone Number: ___________
Employer Name: _______________________ Employer Phone Number: (____) _______-_________
Employer Address: ____
(Street) (City/State/Zip)

Who to call for an emergency:
Name: ____________________________Address: ____
Home Phone: (____) _____-________ Work Phone: (____) _____-______ Relationship: ___________

Primary Insurance Information
Plan Name: ___________________________ I.D. Number: _____________________________
Address: ____ Group Number: _________________
Policy Holder: ____________________________ Effective Date: ______________________
Policy Holder's Social Security Number: ______-_____-_______ Sex: M / F

Secondary Insurance Information
Plan Name: ___________________________ I.D. Number: _____________________________
Address: ____ Group Number: _________________
Policy Holder: ____________________________ Effective Date: ______________________
Policy Holder's Social Security Number: ______-_____-_______ Sex: M / F

Tertiary Insurance Information
Plan Name: ___________________________ I.D. Number: _____________________________
Address: ____ Group Number: _________________
Policy Holder: ____________________________ Effective Date: ______________________
Policy Holder's Social Security Number: ______-_____-_______ Sex: M / F

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to ROOTS / Harmony. I acknowledge that I am financially responsible for payment whether or not covered by insurance. Additionally, there is a $25 no show late cancellation fee for appointments cancelled within less than 24 hours.

Signature: ____ Date: ___________________

CONSENT FOR TREATMENT

General Consent to Treatment: By signing below, I, (or my authorized representative on my behalf) authorize all physicians of GR&W Inc. and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment, or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

__________________________________ ____________

Signature of patient or surrogate Date

INSURANCE WAIVER

I, ______________________, understand the medical insurance and payment policy as outlined in the treatment agreement with which I have been provided. I also understand that some insurance plans do not allow patients to submit claims for payment of services rendered by providers such as GR&W Incorporated (hereafter referred to as GR&W) who do not participate with said insurance plans. I understand that the list of accepted insurance plans may change at any point during my treatment and that I am solely responsible for payment of services rendered outside of insurance coverage in that instance. The list of accepted insurance plans can be provided upon request.

I understand that I am solely responsible for payment for all services rendered by GR&W. I further understand that it is my responsibility to determine, prior to submitting any claim to my insurance company for payment for services rendered by GR&W, whether such claims are permitted by my insurance plan. I release GR&W from any responsibility regarding my medical insurance and acknowledge that any attempt to obtain reimbursement from my insurance company is solely mine and is in no way endorsed by GR&W.

__________________________________ ____________

Signature of patient or surrogate Date

RECEIPT OF PRIVACY PRACTICES

I have received a copy of and have had an opportunity to ask questions about privacy practices of GR&W Inc / ROOTS.

__________________________________ ____________

Signature of patient or surrogate Date

GR&W Inc. / ROOTS
Authorization to Release Information

Patient Name:

Patient's Date of Birth:

Patient's Social Security Number:

I hereby authorize GR&W Inc. / ROOTS to (check one):
_____ obtain from the following _____ release to the following

Name:

Address:

the following documents/information from the records pertaining to services received

Date of Service – From: To:

The documents to be released are described or listed as:

The records are required for the specific purpose of:

I understand that my authorization will remain effective from the date of my signature until such time as I 1) revoke this consent or 2) am no longer a patient of GR&W Inc. and that the information will be handled confidentially in compliance with all applicable federal laws.
I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication.I have read and understand the nature of this release.

____
Signature of Patient or surrogate Date

______________________________ ______________________________
Signature of Witness Date