Patient Registration **(*PLEASE* PRINT CLEARLY)**

Patient's Name: _____ **SSN:** _____
First Name MI Last Name

Date of Birth: _____ _____Male _____ Female _____ Non-Binary

_____Single _____ Married _____ Partnered _____Widowed _____ Divorced _____ Separated

Home Address _____

City/State/Zip Code: _____ **Home Phone w/Area Code:** _____

Cell Phone w/Area Code: _____ E-mail address: _____

May we contact you by email and/or telephone? Yes____ No_____ Which do you prefer? _____

Patient's Employer: _____ **Work Phone w/Area Code:** _____

Spouse's Name: _____ **SSN:** _____

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: _____**Phone Number w/Area Code:** _____

Relationship to Patient: _____

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:** _____

Insurance Company # 2:_____ **Phone Number:** _____

Primary Insured's Name: _____ **Date of Birth:**_____

Policy #:_____ **Group #:**_____ **Relationship:** _____

- ✓ **I hereby authorize the payment of medical benefits to Center Point 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 Center Point to release any medical information necessary to complete and process my insurance claims.**
- ✓ **I authorize the professional staff at Center Point to treat me and use my personal health information for healthcare operations**.
- ✓ **I have received, read and understood the "Attendance and Office Policies"**.

>>_____ _____

Patient's Signature (OR Parent if patient is a Minor, must have Responsible Party Signature) Date

CENTER POINT

ACUPUNCTURE WITH ELIZABETH

Billing Policy & Acknowledgement of HIPAA Privacy Policy

The following sets forth the general billing policy of Center Point. Please review this information and sign below.

- I understand that it is my responsibility to provide the office of Center Point with current, 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 $30 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, cashier's check, or credit card.

- I understand that I will be billed for any amounts due by me 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 (or denial of coverage by insurance company). 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 Center Point 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, Center Point.

_____

Patient's Signature Date

OR

_____

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