PATIENT REGISTRATION FORM

GENERAL INFORMATION:

Name: _____Sex: _____ Birth date: _____
Last First MI

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Marital Status: _____ SSN: _____

Employer: _____ Employer's Address: _____

Work Phone: _____ Drivers License: _____ State: _____

Cell Phone: _____ Emergency Contact: _____ Emergency Contact Phone: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Phone: _____

Name of Insured: _____ ID: _____ Employer: _____

Group #: _____ Relationship to Patient: _____ Birthdate: _____

Secondary Insurance: _____ Phone: _____

Name of Insured: _____ ID: _____ Employer: _____

Group #: _____ Relationship to Patient: _____ Birthdate: _____

FINANCIAL AGREEMENTS (PLEASE INDICATE PREFERENCE)

AT TIME OF SERVICE CASH_____CHECK_____INSURANCE_____

NOTICE OF PRIVACY PRACTICES

I have read and acknowledged the Facility's notice of privacy practices that are posted in the front waiting room. I understand that if I have questions or complaints, I may contact the Facility's Clinical Director.

Please Initial_____

TRANSFER OF RIGHT

I _____transfer right to Lymphedema & Wound Care Consultants of America Inc., Lymphedema & Wound Care Institute of Texas, Inc. and Lymphedema Technologies, Inc. to act on my behalf with respect to any claims filed to my insurance company, including peer to peer reviews, reconsiderations, appeals, hearing (IRO & ALJ) and complaints.

Please Initial _____

AGREEMENT…….PLEASE SIGN-DO NOT PRINT!

___ I, hereby authorize treatment and supplies be rendered by the Lymphedema and Wound Care Institute and their staff and assume financial responsibility for products and services furnished, as indicated above. I hereby authorize payment of medical benefits directly to Lymphedema and Wound Care Institute, and further authorize the release of any medical information and records to my insurance company, physicians and or other related individuals or as necessary to process insurance claims and or initiate a complaint to the Insurance Commissioner for any reason on my behalf. I further authorize that photographs may be taken and used for clinical marketing and research by the Lymphedema and Wound Care Institute. I permit a copy of this authorization to be as valid as the original. All costs of the services and supplies not paid for my insurance company will become my responsibility and accrue interest on the past due balance at a rate of 1 ½ % monthly, ninety (90) days after final payment by my insurance company. All payments shall be first applied to interest and the balance to the principal.

_____ _____

PATIENT'S SIGNATURE **DATE**