

PATIENT REGISTRATION

Title: Mr/Mrs/Ms Circle One

Name: First: _____ MI: _____ Last: _____

Address: _____

City: _____ State: _____ Zip: _____

Please fill in all questions and print clearly

Marital Status: _____ Sex: Female _____ Male _____

Date of Birth: _____ Age: _____

Social Security #: _____ Phone: Home () _____ Work () _____

Cell phone: () _____ e-mail Address: _____

List Drug Allergies: _____

Referred by: 1) _____ Doctor: _____

2) _____ Doctor: _____

Patient Employer: _____ Occupation: _____

Employer Address: _____

Spouse's Name: _____ Spouse's Social Security #: _____

Spouse's Employer: _____ Spouse's DOB: _____ Spouse's work #: _____

Person to contact in case of emergency: _____

Phone #(Different than numbers given above): _____ Relationship: _____

Insurance: Yes _____ No _____

Is this Worker's Compensation Related: Yes _____ No _____

If yes, date of Accident: _____

Responsible Party (if other than Patient)

Name: First: _____ MI: _____ Last: _____

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

Home Phone #: _____ Wk Phone #: _____ SS#: _____

Employer: _____

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

INSURANCE INFORMATION

PRIMARY

Patient Name: _____ Medicare #: _____

Insurance Name: _____ Policy #: _____ Group #: _____

Group Name: _____ Guarantor: _____ Relationship: _____

Insurance Address: _____

Insurance Phone #: _____ Is Precertification Required? Yes ___ No ___

SECONDARY

Insurance Name: _____ Policy #: _____ Group #: _____

Group Name: _____ Guarantor: _____ Relationship: _____

Insurance Address: _____

Insurance Phone #: _____ Is Precertification Required? Yes ___ No ___

NOTE:

1. Services are rendered to the patient, not the insurance company.
2. **IF MEDICARE IS YOUR PRIMARY INSURANCE, PAYMENT IN FULL IS REQUIRED AT THE TIME OF SERVICE.** We will file your insurance as a courtesy, and insurance reimbursements will be made directly to the patient.
3. It is your responsibility to notify our front desk staff of any insurance or address changes.
4. **ANY INSURANCE-PENDING BALANCE AFTER 60 DAYS IS THE RESPONSIBILITY OF THE PATIENT.**

PATIENT AUTHORIZATION

I authorize Dr. Balch and/or his associates, or anyone on their behalf, to submit Medicare or other insurance claims using my signature on file below. I authorize the release of any medical information necessary in order to process the claim.

Patient Signature

Date

If patient is a minor, parent or guardian signature

**PATIENT CONSENT FOR USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

With your consent, Dr. Balch and/or his associates, or anyone on their behalf, may use and disclose protected health information (PHI) about you to carry out treatment, payment, and healthcare operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures. You have the right to review our Notice of Privacy Practices prior to signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy Office at 5555 Peachtree Dunwoody Rd., Suite 281, Atlanta, GA 30042.

With your consent, Dr. Balch and/or his associates, or anyone on their behalf, may call your home or office and leave a message in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any call pertaining to your clinical care.

With your consent, Dr. Balch and/or his associates, or anyone on their behalf, may mail to your home or office any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements.

You have the right to request that we restrict how we use or disclose your PHI to carry our treatment, payment, and healthcare operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound by our agreement.

By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment, payment, and healthcare operations. This consent may be revoked in writing except that we may have already made disclosures in reliance upon your prior consent. If you decline to sign this consent, we may decline to provide treatment for you.

Signature of Patient or Legal Guardian: _____

Patient Name: _____

Print Name of Patient or Legal Guardian: _____

Date: _____