

PATIENT REGISTRATION

PATIENT INFORMATION

Name: _____
DOB: _____ SS#: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell#: _____ Work#: _____
Occupation: _____ Employer: _____
Address: _____
City: _____ State: _____ Zip: _____
Emergency Contact: _____ Phone: _____

INSURANCE INFORMATION

Health Insurance Medicare Medicaid Private Insurance
Is this diagnosis a result of a motor vehicle accident? YES NO If yes, inform the office staff immediately.
Insurance Co: _____ ID#: _____
Insured Name: _____ Relation to patient: _____
Insured Date of Birth: _____
Secondary Insurance Co: _____ ID#: _____
Insured Name: _____ Relation to Patient: _____
Insured Date of Birth: _____

WORKER'S COMP OR AUTO INSURANCE

Worker's Comp Auto Insurance
Insurance Co: _____ Claim #: _____
Billing Address: _____
City: _____ State: _____ Zip: _____
Adjuster/Lawyer: _____ Phone: _____
Person/Party responsible for payment: _____

REFERRAL INFORMATION

Referring MD: _____
PCP: _____
Date of injury/surgery: _____
Return date to see MD: _____

How were you referred to us? (please check)

Physician Friend/family

Phone Book:

Concord Manchester Nashua

Other: _____

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize the release of information to my doctor and to my insurance company necessary to process this claim.

Initials: _____

PATIENT PRIVACY POLICY: I acknowledge that a copy of NHHTC patient privacy policy was offered or issued to me.

Initials: _____

ASSIGNMENT OF PAYMENT: I assign payment of medical benefits to NH Hand Therapy Center, Inc. for services rendered.

Initials: _____

TO OUR MANAGED CARE PATIENTS: Your signature below indicates that if you received any services at NHHTC and the fees are denied because you did not obtain prior approval from your primary care physician, you will be personally responsible for those fees.

Initials: _____

CANCELLATION POLICY: Appointments cancelled without 24 hours notice will result in a \$25.00 charge that I am *personally* responsible for. Three missed appointments without 24 hours notice could result in discharge for non-compliance.

Initials: _____

RESPONSIBILITY FOR PAYMENT: I understand that I am responsible for full payment for services rendered. Any charges not covered by my insurance company, including copayments, deductibles, splints, and supplies, will be payable at the time of treatment. I will be responsible for all fees for services rendered that are not covered by insurance.

Initials: _____

All balances not paid within thirty (30) days of invoice will bear interest at a rate of one and one-half percent (1½%) per month, or eighteen percent (18%) per annum until paid in full. If I default in making timely payments on my account, I will be responsible for all costs of collection including attorney fees and court costs.

Initials: _____

I HAVE READ AND AGREE TO THE ABOVE MENTIONED POLICIES.

Signature of Patient/Legal Guardian

Date

Witness

Date

PLEASE READ AND SIGN THE REVERSE SIDE OF THIS FORM