PLEASE PRINT ALL INFORMATION CLEARLY

PATIENT REGISTRATION

NAME | SOCIAL SECURITY # | BIRTH DATE

STREET | CITY/STATE | ZIP

PRIMARY PHONE # | MARITAL STATUS | MALE / FEMALE

OTHER PHONE # | SPOUSE NAME | PHONE #

EMERGENCY CONTACT | PRIMARY PHONE # | OTHER PHONE #

EMAIL ADDRESS:

HOW DID YOU LEARN ABOUT OUR OFFICE?

PATIENT EMPLOYER INFORMATION

EMPLOYER NAME | PHONE #

EMPLOYER ADDRESS | CITY/STATE | ZIP

OCCUPATION / TYPE OF WORK

INSURANCE INFORMATION

PRIMARY INSURANCE | ID # | GROUP #

SUBSCRIBER NAME | RELATIONSHIP (to patient)

SUBSCRIBER DATE OF BIRTH | EMPLOYER

SECONDARY INSURANCE | ID # | GROUP #

SUBSCRIBER NAME | RELATIONSHIP (to patient)

SUBSCRIBER DATE OF BIRTH

RESPONSIBLE PARTY (GUARANTOR) IF PATIENT IS A MINOR

NAME | SOCIAL SECURITY #

STREET | CITY/STATE | ZIP

BIRTH DATE | RELATIONSHIP TO PATIENT

PHONE # | EMPLOYER

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process insurance claims on my behalf. I permit a copy of this authorization in the place of the original.

If Kevin C. Harrison, D.O. *does participate* with my insurance company, I hereby authorize him to apply for payment of benefits on my behalf for covered services rendered by him or by his order.

I request payment from my insurance company to be made directly to the doctor.

I agree to be responsible for my bill, in full, if my insurance company has not paid my claim within 90 days.

If the doctor *does not participate* with my insurance company, I understand that I am solely responsible for all charges incurred by me, and full payment will be paid by me at the time of service. I further understand that a claim will be submitted by this office to my insurance company with the benefits paid directly to me.

If my account is referred to an attorney or collection agency for collection, I agree to pay all collection fees and court costs, including attorney's fees or collection agency fees in the amount of thirty-three and one third (33 1/3%) of the total debt due.

I certify that the information I have provided on this form is true and correct to the best of my knowledge.

My signature below indicates I have read and I understand the above information.

DATE: **SIGNATURE:**