MARYLAND ACUPUNCTURE CLINIC

PATIENT REGISTRATION – *Please print clearly*

PATIENT INFORMATION: **Today's Date____/____/____**

Full Name_____ **Date of Birth** _____/_____/_____ **Age** _____ **Male** ☐ **Female** ☐

Address_____ **SN** _____-_____-_____

City_____ **State**_____ **Zip** _____ **Home Phone ( )** _____

Alternate Phone (Cell) ( ) _____ **Email Address**_____

Employer's Name_____ **Occupation**_____

Work Address_____ **City**_____ **State**_____ **Zip** _____

Work Phone ( ) _____ **Ext.**_____ **How did you hear about us?**_____

MARITAL STATUS: Single ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Date Symptoms Began** _____/_____/_____

Emergency Contact_____ **Phone ( )**_____

CLAIM INFORMATION:

Is your condition due to: Auto Accident ☐ **Personal Injury** ☐ **Work Injury** ☐ **Other** ☐

Type of Claim: Cash ☐ **Group Health Ins** ☐ **Personal Injury** ☐ **Worker's Comp** ☐ **Medicare** ☐

INSURANCE INFORMATION:

Relationship to Insured: Self ☐ **Spouse** ☐ **Other** ☐ **Child** ☐ **Spouse Name:**_____

Insured's Employer or Same as above ☐ _____

Insured's SSN or Same as above ☐ _____-_____-_____ **Insured's DOB or Same as above** ☐ _____/_____/_____

PRIMARY Insurance Co._____ **Address**_____

City_____ **State**_____ **Zip** _____ **Phone ( )** _____

Policy Number_____ **Group Number**_____

Referring Physician (if applicable)_____ **Phone ( )** _____

SECONDARY Insurance Co._____**Address**_____

City_____ **State**_____ **Zip** _____ **Phone ( )**_____

Policy Number_____ **Group Number**_____

AUTHORIZATIONS:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to Maryland Acupuncture Clinic (MAC). I authorize the direct payment to MAC of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident policies are in arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature_____ **Date:**_____

Guardian's Signature_____ **Date:**_____