Hanger CLINIC
Empowering Human Potential

PATIENT REGISTRATION

SECTION 1: PATIENT INFORMATION

Personal Information

☐Mr ☐Ms ☐Mrs First: _____ MI:___ Last: _____

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

Email Address: _____ Cell: _____

Home Phone: _____ Work Phone: _____

Emergency Contact Phone: _____

Social Security Number: _____

☐ Male or ☐ Female Marital Status: _____ DOB: _____

Guarantor: _____ Patient Relationship to Guarantor: ☐ Self ☐ Spouse ☐ Child ☐ Other

Guarantor Address: _____ City: _____ State: ____ Zip: _____

Phone: _____

Physician Information

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Condition Information

Are you diabetic? ☐ Yes ☐ No If yes, name and address of physician treating your diabetes:

Physician Name: _____ Phone: _____

Address: _____

Have you received a similar service in the past five years? ☐ Yes ☐ No

Are you in hospice care? ☐ Yes ☐ No

Are you a resident of a skilled nursing (nursing home) facility? ☐ Yes ☐ No

Was your condition the result of an accident? ☐ Yes ☐ No *If no, please skip to Insurance Information below.*

Was your injury work related? ☐ Yes ☐ No *If yes, name of employer at time of accident:*

Employer Name: _____ Date of Injury: _____

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

Contact Person: _____ Phone: _____ Claim #: _____

Was your injury the result of an automobile accident? ☐ Yes ☐ No *If yes, name of adjuster:*

Name: _____ Phone: _____ Claim #: _____

Current Employer: _____

SECTION 2: INSURANCE INFORMATION

Primary Insurance: _____

Address: _____ Phone: _____

Policy #: _____ Claim #: _____

Secondary Insurance: _____

Address: _____ Phone: _____

Policy #: _____ Claim #: _____

Please present the receptionist with your insurance card(s) so we may make copies.

I certify that the information provided by me is true, accurate and complete.

Signature of Patient / Guarantor _____ *Date* _____

Patient Registration Signature Form

Patient Name (please print clearly):_____

I understand that there are some circumstances that may require you to contact me regarding my care. By signing this form, I authorize Hanger Clinic to contact me regarding appointments, treatment instructions, billing/account information or other matters specific to my care.

Please check which the following modes of communication Hanger Clinic may use to contact you:

How may we contact you (check all that apply)? ☐ **Voice Messages** ☐ **Emails** ☐ **Text Messages**

Home #_____ Work #_____ Mobile/Text*#:_____ Email: _____**

Revocation of authorization to contact me via email and/or text: I understand that I may revoke my consent for future communications via email and/or text at any time by advising Hanger Clinic in writing. My revocation of authorization will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

Authorization for disclosure of PHI: I authorize Hanger Clinic to share information regarding my treatment, or payment for treatment, with the following individuals:

☐ Spouse or partner (name) _____ ☐ None

☐ Other Individual (name)_____ ☐ Relationship to Patient_____

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Hanger Clinic or any of its subsidiaries for any covered services furnished by Hanger Clinic. I agree to pay to Hanger Clinic the deductible and/or coinsurance on my claim. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents, Champus / TRICARE and its agents, or to any private insurance company any information needed to determine these benefits or the benefits payable for related services.

Your signature below is an acknowledgement that you have received or been given the opportunity to receive a copy of Hanger's Notice of Privacy Practices.

X_____
Signature of Patient or Responsible Party Date

X_____ Relationship to Patient _____
Signature of Representative (acknowledging receipt only) Date

X _____ _____
Signature of Witness (if patient signing with a mark) Date Printed Name of Representative or Witness

☐ Patient Refused to Sign for Receipt of the NPP ☐ Patient is incapacitated ☐ Other (Please explain)

Reason for Patient's Inability/Refusal to Sign*** _____

*Text Communications: I understand that text message charges from my mobile phone provider may apply. Please be advised that text communication is not always secure. Text messages can be intercepted and, for this reason, we do not communicate personal health information through this method. I will ensure that I keep Hanger Clinic informed of my up-to-date mobile number at all times or if the number is no longer in my possession. Note, texting is only used for appointment reminders and voluntary survey participation requests.

**Email Communications: (Hanger Clinic utilizes encrypted email) In authorizing Hanger Clinic to communicate with me by email, I acknowledge that: (a) email is not a secure medium for sending or receiving information and accordingly, there is a possibility that my emails may be read or otherwise accessed by a third party in transit (b) although Hanger Clinic will make reasonable efforts to keep email communications confidential and secure, Hanger Clinic cannot assure or guaranty the confidentiality of email communications; (c) in the discretion of Hanger Clinic, email communications may be made a part of my permanent medical record; and (d) email is not an appropriate means of communication regarding emergency or other time-sensitive issues or for inquiries regarding sensitive information. Accordingly, I agree that I will not use email to communicate regarding emergencies or other time-sensitive issues, or to communicate regarding other sensitive information. If I do not receive a response to my email message within two (2) days, I agree I will use another means of communication to contact Hanger Clinic.

***Hanger made good faith efforts to obtain the above referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices