PATIENT REGISTRATION

Hanger Clinic
Empowering Human Potential

SECTION 1: PATIENT INFORMATION

PERSONAL INFORMATION

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

DOB: _____ Sex: ☐ Male ☐ Female Marital Status: _____ Preferred Language: _____

Address: _____ City: _____ State: _____ ZIP: _____

Primary Phone: _____ Type: ☐ Cell ☐ Home ☐ Work ☐ Other: _____ Email: _____

Emergency Contact: _____ Relation to Patient: ☐ Spouse ☐ Child ☐ Other: _____

Contact Phone: _____ Type: ☐ Cell ☐ Home ☐ Work ☐ Other: _____

Is patient also the guarantor? ☐ Yes ☐ No *If yes, skip to PHYSICIAN INFORMATION.*

Guarantor Name: _____ Relation to Patient: ☐ Spouse ☐ Child ☐ Other: _____

Guarantor Phone: _____ Address: _____ City: _____ State: _____ ZIP: _____

PHYSICIAN INFORMATION

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

CONDITION INFORMATION

Are you diabetic? ☐ Yes ☐ No *If yes, provide the name and address of the physician treating your diabetes.*

Physician Name: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Have you received a similar service in the past 5 years? ☐ Yes ☐ No

Are you in hospice care? ☐ Yes ☐ No

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

Was your condition the result of an accident? ☐ Yes ☐ No *If no, skip to INSURANCE INFORMATION.*

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

Employer Name: _____ Date of Injury: _____

Address: _____ City: _____ State: _____ ZIP: _____

Contact: _____ Phone: _____ Claim #: _____

Was your injury the result of an automobile accident? ☐ Yes ☐ No *If no, skip to INSURANCE INFORMATION.*

Insurance Adjuster Name: _____ Phone: _____ Claim #: _____

SECTION 2: INSURANCE INFORMATION

Please be sure to bring your insurance cards and photo ID to your appointment.

Primary Insurance: _____ **Policy #:** _____ **Group #:** _____

Subscriber Name (if different than patient): _____

Address: _____ Phone: _____

Secondary Insurance: _____ **Policy #:** _____ **Group #:** _____

Subscriber Name (if different than patient): _____

Address: _____ Phone: _____

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 of the following modes of communication Hanger Clinic may use to contact you **(check all that apply):**

☐ **Voice Messages** ☐ **Secured Emails*** ☐ **Unsecured Emails****
☐ **Secured Text Messages#*** ☐ **Unsecured Text Messages#****

Home #: _____ **Work #:** _____ **Mobile #:** _____ **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 understand 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 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, Campus/TRICARE and its agents, or any private insurance company any information needed to determine these benefits or the benefits payable for related services.

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

_____ _____
Signature of Patient or Responsible Party Date

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

_____ _____ _____
Signature of Witness (if patient signed with a mark) Date Printed Name of 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.
*Unless requested otherwise, emails and texts will be sent encrypted, excluding appointment reminders.
**I acknowledge that unsecured email/texts are not a secure medium for sending or receiving protected information. There is a possibility that my emails and text messages may be read or otherwise accessed by a third party in transit. Although Hanger Clinic will make a reasonable effort to keep email and text communication confidential and secure, Hanger cannot assure or guarantee the confidentiality of email/text communications.
***Hanger made good faith efforts to obtain the above referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices.