LHS Patient Registration

DATE _____

PATIENT _____Age _____Date of Birth _____

Mailing Address _____ SSN _____ M or F

_____ Home Phone _____

Physical Address _____

Cell Phone _____ email: _____

I consent to receive calls including pre-recorded and automated calls, texts and emails unless I notify LHS in writing.

Employer_____ Occupation _____

Work Phone _____ Address _____

SPOUSE _____ Date of Birth _____

Employer _____ Social Security No. _____
Work
Address _____ Work
Phone _____
Relationship to
GUARANTOR _____ **Patient** _____

EMERGENCY CONTACT:_____ **Phone #** _____

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PRIMARY
INSURANCE _____ Subscriber SELF SPOUSE

SECONDARY
INSURANCE _____ Subscriber SELF SPOUSE

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RELEASE OF INFORMATION, BENEFIT ASSIGNMENT, PAYMENT AUTHORIZATION, FULL DISCLOSURE STATEMENT, PERMISSION TO TREAT, RECEIPT OF PRIVACY POLICY AND AGREEMENT TO PAY FOR SERVICES

I hereby authorize **LHS** to release any information necessary to process my insurance/Medicare claim, acquired in the course of my examination or treatment; to allow a photocopy of my signature to be used to process my insurance/Medicare claim for the period of **LIFETIME**. I claim any insurance benefits due me for services rendered by **LHS** and authorize and direct my carrier to issue payment check(s) directly to **LHS.** Regardless of my insurance benefits, I understand that I am fully financially responsible for any and all fees incurred, and I agree to pay such fees in full. The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose pre-certification/second opinion requirements for any and all plans to which I subscribe, may cause me to incur full liability for professional charges, as a result of non-payment by any carrier. Permission to treat is granted for such medical and surgical treatment as deemed necessary. I acknowledge that I have received a copy of LHS' Notice of Privacy Practices. I have been provided an opportunity to ask questions about the practices as they pertain to protected health information.

_____ _____

Patient Signature **Date**