

**Patient Registration**

**(PLEASE PRINT CLEARLY!)**

Patient's Name: \_\_\_\_\_ SS #: \_\_\_\_\_  
First Name MI Last Name

Date of Birth: \_\_\_\_\_ \_\_Male \_\_ Female \_\_Single \_\_Married \_\_Widowed \_\_ Divorced \_\_ Separated

Street Address : \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_ Home Phone w/Area Code: \_\_\_\_\_

Cell Phone w/Area Code: \_\_\_\_\_ Fax w/Area Code: \_\_\_\_\_

e-mail Address: \_\_\_\_\_ Can this be used for communicating with you? Yes\_\_ No\_\_

Spouse's Name: \_\_\_\_\_ SS #: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's Work Phone #: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Work Phone w/Area Code: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Relationship: \_\_Self \_\_Spouse \_\_Parent \_\_Other: \_\_\_\_\_

If patient is a Minor, are parents \_\_Married \_\_Divorced Custodial Parent: \_\_\_\_\_

Custodial Parent's Home Phone w/Area Code: \_\_\_\_\_ Work Phone w/Area Code: \_\_\_\_\_

In case of emergency, contact (not living with you): \_\_\_\_\_

Phone Number w/Area Code: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Is this work-related? \_\_Yes \_\_No If yes, date of injury? \_\_\_\_\_ Claim #: \_\_\_\_\_

Is this auto accident related? \_\_Yes \_\_No If yes, date of injury? \_\_\_\_\_ Claims# \_\_\_\_\_

Insurance Company to be billed \_\_\_\_\_

Adjuster's Name & Phone # \_\_\_\_\_

Attorney's Name & Phone # \_\_\_\_\_

Referring Physician's Name & Phone Number: \_\_\_\_\_

**PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFORMATION**

Insurance Company # 1: \_\_\_\_\_ Phone Number: \_\_\_\_\_

>>Primary Insured's Name: \_\_\_\_\_ >>Date of Birth: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Insurance Company # 2: \_\_\_\_\_ Phone Number: \_\_\_\_\_

>>Primary Insured's Name: \_\_\_\_\_ >>Date of Birth: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

- I hereby authorize the payment of medical benefits to Sara E. O'Leary, L.Ac, M.Ac., for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier. I permit a copy of this authorization to be used in place of the original.
- I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.
- I hereby authorize Sarah E. O'Leary, L.Ac., M.Ac. to release any medical information necessary to complete and process my insurance claims.

>> \_\_\_\_\_ Date  
>>Patient's OR Insured's Signature (If patient is a Minor, must have Responsible Party Signature)

I authorize Sarah E. O'Leary, L.Ac., M.Ac. to treat me and use my personal health information for healthcare operations.

>> \_\_\_\_\_ Date  
>>Patient's Signature (OR Parent if patient is a Minor)

## Billing Policy & Acknowledgement of HIPAA Privacy Policy

The following sets forth the general billing policy of Seeds Center for Whole Health, LLC. Please review this information and sign where indicated.

- ❖ I understand that it is my responsibility to provide the office of Seeds Center for Whole Health, LLC with current, accurate billing information at the time of check in and to notify the provider of any changes in this information.
- ❖ I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that the provider also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.
- ❖ I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a \$25 NSF fee. I further understand that to rectify my account, I will be required to pay with either cash, a money order, cashier's check, or credit card.
- ❖ I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/ deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.
- ❖ I understand that the provider will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.
- ❖ I have received a copy of the Notice of Privacy Practices as required by HIPAA from Seeds Center for Whole Health, LLC and understand my rights with regard to my personal health information disclosure.

My signature below confirms that I have read and understand these billing policies, privacy practices and my financial obligation as pertains to the health care provider, Seeds Center for Whole Health, LLC.

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Patient's Signature

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Date

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Legal Guardian to Patient (if patient is minor or incapable of signing)