

PATIENT INFORMATION			
Name: Last		First	Middle
Date of Birth:		SSN (Required for insurance)	
Home Street Address:			Apt:
City:		State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> Sep <input type="checkbox"/> D <input type="checkbox"/> W
Preferred Phone: <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Cell Phone		Email (for test results & necessary communication)	
Employer: _____ <input type="checkbox"/> Employed (FT) <input type="checkbox"/> Employed (PT) <input type="checkbox"/> Student (FT) <input type="checkbox"/> Student (PT) <input type="checkbox"/> Unemployed		Occupation	
How did you hear about us? <input type="checkbox"/> Internet (Search Engine: _____ / Website: _____) <input type="checkbox"/> Doctor: _____ <input type="checkbox"/> Friend <input type="checkbox"/> Other: _____		NAME OF PHARMACY / Location _____ • Ph. Number _____ • Fax. Number _____	
EMERGENCY CONTACT			
Emergency Contact:		Relationship:	Contact Phone:
PRIMARY INSURANCE			
Name of Primary Insurance Company (REQUIRED)		Type: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> Other	
Name of Policy Holder / Subscriber (REQUIRED):		Relationship to Subscriber (REQUIRED): <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Subscriber Sex <input type="checkbox"/> M <input type="checkbox"/> F
Insurance ID # (REQUIRED)	Group (REQUIRED)	Subscriber date of birth (REQUIRED)	
Employer of Subscriber (REQUIRED)		Occupation:	
SECONDARY INSURANCE (IF YOU HAVE SECONDARY INSURANCE YOU MUST SUPPLY THIS INFORMATION)			
Name of Secondary Insurance Company		Type: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> Other	
Subscriber/Policy Holder		Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Subscriber Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Insurance ID # :	Group:	Subscriber Date of Birth (REQUIRED)	
Employer of Subscriber		Occupation	
<p>I hereby give permission for Regional Health Partners, LLC (or its designee) provide medical care for me (or my minor child).</p> <p><i>Assignment of Medical Benefits:</i> I request that payment of authorized Medical Insurance benefits be made either to me or on my behalf to RHP (or its designee) for any services furnished to me by that physician or supplier. I authorize any holders of medical information about me to release to the insurance processor, and its agents any information needed to determine these benefits or the benefits payable for related service.</p> <p><i>Assignment of Commercial Insurance Benefits:</i> I hereby authorize RHP (or its designee) to collect payment for services rendered by Regional Health Partners, LLC (RHP) & its designee. I understand and agree that I am financially responsible for charges not paid under this insurance policy. Should the account be turned over to a collection agency for collection, the undersigned shall pay all collection agency, court, and reasonable attorney fees.</p> <p>I understand that my insurance information may be released to medical service and product providers by RHP including, but not limited to laboratories, DME providers and pharmacies as necessary to bill for medical services and equipment provided by these companies. These providers will independently bill my insurance, and will bill me for any deductibles, copays and coinsurances due. I further understand that RHP is not responsible in any way for any bill I may receive from these providers.</p>			
PATIENT SIGNATURE:			DATE:

Dr. Feuer NPI: 1710042106	Dr. McIntosh NPI: 1538176870	Dr. Noonan NPI: 1952517997
[Tax ID: 46-2026732]		

Name of Patient _____

Today's Date _____

Spoke To _____

Effective Date _____

Benefit Checked _____

Diagnosis Code _____

CPT Code _____

- NOT Covered
- Covered _____%

• Specialist O.V Copay \$ _____

• Deductible _____

➤ Met _____

➤ Remaining _____

Referral:	YES	NO
Pre-Authorization:	YES	NO