PATIENT INFORMATION

Name: Last First Middle	Date of Birth:	SSN

Home Street Address:	Apt:

City:	State:	Zip Code:

Home Phone:	Cell Phone:	Work Phone:	Marital Status ❑ S ❑ M ❑ Sep ❑ D ❑ W

Preferred Phone: ❑ Home Phone ❑ Work Phone ❑ Cell Phone	Email **(for test results & necessary communication)**

Employer: ____ ❑ Employed (FT) ❑ Employed (PT) ❑ Student (FT) ❑ Student (PT) ❑ Unemployed	Occupation

How did you hear about us? ❑ Internet (Search Engine:____________________ / Website:____________________) ❑ Doctor:___________________ ❑ Friend ❑ 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: ❑ HMO ❑ PPO ❑ POS ❑ Other

Name of Policy Holder / Subscriber **(REQUIRED):**	Relationship to Subscriber **(REQUIRED):** ❑ Self ❑ Spouse ❑ Child ❑ Other	Subscriber Sex ❑ M ❑ 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: ❑ HMO ❑ PPO ❑ POS ❑ Other

Subscriber/Policy Holder	Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	Subscriber Sex: ❑ M ❑ F

Insurance ID # :	Group:	**Subscriber Date of Birth (REQUIRED)**

Employer of Subscriber	Occupation

I hereby give permission for Regional Health Providers, LLC (or its designee) provide medical care for me (or my minor child).

Assignment of Medical Benefits: 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 suppler. 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.

Assignment of Commercial Insurance Benefits: I hereby authorize RHP (or its designee) to collect payment for services rendered by Regional Health Providers, 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.

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.

PATIENT SIGNATURE:	**DATE:**