HARMONY TRANSFORMATIONS ROOTS

Patient Registration Form

Patient Name: _____ SSN:_____
Patient DOB: _____ Sex: Male / Female
Email Address:_____
Would you be interested in having communications sent to you via email? (Ex: Appointment reminders, Administrative updates, and health bulletins) Yes / No
Address:_____City:_____State:_____Zip:_____
Cell Phone Number:_____ Work Phone Number:_____
Primary Care Physician:_____ Phone Number:_____
How did you hear about us? _____
_____

Person responsible for Bill or Payment (Only complete this section if different from above patient)
Name: _____ SSN:_____
DOB: _____ Sex: Male / Female Phone Number:_____
Address:_____City:_____State:_____Zip:_____
Cell Phone Number:_____ Work Phone Number:_____
Employer Name:_____
Employer Address_____
_____

Emergency Contact
Name: _____ Relationship:_____
Address:_____City:_____State:_____Zip:_____
Cell Phone Number:_____ Work Phone Number:_____
_____

Insurance Information
Primary Plan Name:_____ ID Number:_____
Group Number:_____ Date Effective:_____ Policy Holder's Name:_____
Policy Holder's SSN:_____ Policy Holder's DOB:_____
Claims Address:_____City:_____State:_____Zip:_____
Secondary Plan Name:_____ ID Number:_____
Group Number:_____ Date Effective:_____ Policy Holder's Name:_____
Policy Holder's SSN:_____ Policy Holder's DOB:_____
Claims Address:_____City:_____State:_____Zip:_____
Tertiary Plan Name:_____ ID Number:_____
Group Number:_____ Date Effective:_____ Policy Holder's Name:_____

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Policy Holder's SSN:_____ Policy Holder's DOB:_____
Claims Address:_____City:_____State:_____Zip:_____

Patient Printed Name:_____ Date of Birth:_____

I authorize the release of any medical information necessary to process this bill, to my insurance company, and request payment of benefits to GR&W Inc. I acknowledge that I am financially responsible for the payment whether or not covered by insurance. Additionally, I understand that there is a $50 No Show/ Late Cancellation fee for appointments cancelled within less than 24 hours.

Signature:_____ Date:_____

General Consent to Treatment: By signing below, I (or my authorized representative on my behalf) Authorize all physicians of GR&W Inc. and their staff to conduct any diagnostic examinations, tests, and procedures and to provide any medications, treatment, or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reason for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options, as well as alternative courses of treatment.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy, or medication recommended or deemed medically necessary by my individual treating healthcare providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

Signature:_____ Date:_____

Insurance Waiver: I understand the medical insurance and payment policies as outlined in the agreement with which I have been provided. I also understand that some insurance plans do not allow patients to submit claims for payment of services rendered by providers such as GR&W Inc., who do not participate with said insurance plans, I understand that the list of accepted insurance plans may change at any point during my treatment and that I am solely responsible for payment of services rendered outside of insurance coverage in that instance. The list of accepted insurance plans can be provided upon request.

I understand that I am solely responsible for payment for all services rendered by GR&W Inc. I further understand that it is my responsibility to determine, prior to submitting any claim to my insurance company for payment for services rendered by GR&W Inc., whether such claims are permitted by my insurance plan. I release GR&W Inc. from any responsibility regarding my medical insurance and acknowledge that any attempt to obtain reimbursement from my insurance company is solely mine and is in no way endorsed by GR&W Inc.

Signature:_____ Date:_____

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Receipt of Privacy Practices: I have received a copy of and have had an opportunity to ask questions about the privacy practices of GR&W Inc.

Signature:_____ **Date:**_____

Release of Information

Patient Name: _____ Patient DOB: _____ Last #4 of SSN: _____

I hereby authorize GR&W, inc. to: _____ obtain from the following and/or _____ release to the following:

Physician/Clinic:_____

Name: _____ Phone Number: _____

Address: _____

Fax Number: _____ Email Address: _____

Check All Records to be Released:

▢ Mental Health ▢ All Medical Records ▢ Patient Scheduling

▢ Billing ▢ Lab/ Tests Results ▢ Follow-up Exams

▢ Drug/Alcohol Abuse ▢ Other (specify): _____

Purpose of Records Release:

▢ Continuity of Care ▢ Disability Claims ▢ Patient Request/Personal Copy

▢ Legal Claims ▢ Insurance Claims ▢ School/ Employment Request

▢ Other (specify): _____

This authorization is in effect From: _____ To: _____

I understand that my authorization will remain effective from the date of my signature until such time as I 1) revoke this consent or 2) am no longer a patient of GR&W, Inc. and that the information will be handled confidentially in compliance with but not limited to PA Law (55 PA3800.20), Federal Regulations (42CFR Part) and/or HIPAA (CFR 164.508). I understand that I may revoke the authorization at any time by written, dated communication. I have read and understand the nature of this release. I hereby release GR&W, Inc. from liability which may arise as a result of the information disclosed by this authorization, should it presumed that information is later to my detriment.

_____ _____

Signature of Patient or Surrogate **Date Signed**

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Signature of Witness **Date Signed**

A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL