PATIENT REGISTRATION

Lustig Health & Wellness
1950 Keene Rd Bldg J, Richland, WA. 99352
Phone (509) 943-6800 Fax (509) 491-3900

Patient Information

Name:_____ Date of Birth:_____
Last First MI

Address:_____ City:_____ State:____ Zip:_____

Phone Cell (___) _____ Work (___) _____ Home (___) _____

(Please Check Mark the Number to Call Between 8:30am – 5:00)

Email:_____

Male___ Female___ Single___ Married___ Other___ Employed___ Not-Emplyed___ Student___

(Please Check Mark all that Apply)

Employer Information (If Applicable)

Employer Name:_____Occupation:_____

Address:_____ City:_____ State:____ Zip:_____

Spouse's Information (If Applicable)

Spouse's Name:_____

Last First

Emergency Contact Information

Contact Name:_____ Phone:_____ Relationship:_____

Insurance Information

Primary Insurance Carrier:_____

Secondary Insurance Carrier:_____

How Did You Hear About our Office?_____

(Please Mention Name of Person, Thanks)

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Patient Name:_____ **Date of Birth:**_____

*I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations (TPO). I have been informed that I may review the practice notice of privacy practice (for a more complete description of use and disclosures) before signing this consent.

*I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice. I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restrictions(s).

*I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used and disclosed.

Signature:_____ **Date:**_____
(Patient, Parent, or Legal Guardian)

Insurance and Cancellation Policy

Your Insurance is a contract between you and your insurance company. Our office will file primary and secondary claims on your behalf. Our office CANNOT guarantee that your insurance will pay your claim. **If your claim is denied, the obligation for the payment is the responsibility of the patient.** Our office will NOT enter a dispute with your insurance company. **All cancellations of your appointment MUST be made no less than 24 hours before you appointment.** Failure to do so will result in a penalty charge of **$50.00**- this fee is NOT covered by your insurance and will be the sole responsibility of the patient. **Two (2) No-Show appointments will be cause for termination from the practice.**

Signature:_____ **Date:** _____
(Patient, Parent, or Legal Guardian)

Family and Friends Release of Information Consent

Lustig Health & Wellness Center has my consent to:

Y N Leave medical information on my home answering machine.

Y N Contact me at my place of employment'

Y N Leave medical information on voicemail at place of employment.

I Authorize Lustig Health & Wellness Center to discuss ANY information regarding my care with below-mentioned persons: (Only list names of persons you are authorizing us to discuss ANY information with)

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Signature: _____ **Date:** _____

This Authorization is valid until revoked by the patient in writing at any time.