Hanger CLINIC
Empowering Human Potential

Patient Registration Signature Form

Patient Name _____

I understand that there are some circumstances that may require you to contact me regarding my care. By initialing and signing below, I authorize Hanger Clinic to contact me at the following (please initial all that apply):

	Home Number	Work Number	Mobile Number	Email*
Appointments				
Treatment Instructions				
Billing / Account Information				
Other (please indicate)				
I do not want any voice messages left and / or email				

I authorize Hanger Clinic to share information regarding my treatment, or payment for treatment, with the following individuals:

- ☐ My spouse or partner (name) _____
- ☐ My son or daughter (name) _____
- ☐ Other individual (name) _____
- ☐ None

Your signature below is an acknowledgement that you have received or been given the opportunity to receive a copy of Hanger's Notice of Privacy Practices.

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Hanger Clinic or any of its subsidiaries for any covered services furnished by Hanger Clinic. I agree to pay to Hanger Clinic the deductible and/or coinsurance on my claim. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents, Champus / TRICARE and its agents, or to any private insurance company any information needed to determine these benefits or the benefits payable for related services.

X_____ Date _____
Signature of Patient or Responsible Party

X_____ Date _____
Signature of Representative (acknowledging receipt only)

Relationship to Patient _____

X_____ Date _____
Signature of Witness (if patient signing with a mark)

Printed Name of Representative or Witness _____

Address of Representative or Witness _____

Reason for Patient's Inability to Sign _____

***Email Communications.** (Hanger Clinic utilizes encrypted email) In authorizing Hanger Clinic to communicate with me by email, I acknowledge that: (a) email is not a secure medium for sending or receiving information and accordingly, there is a possibility that my emails may be read or otherwise accessed by a third party in transit; (b) although Hanger Clinic will make reasonable efforts to keep email communications confidential and secure, Hanger Clinic cannot assure or guaranty the confidentiality of email communications; (c) in the discretion of Hanger Clinic, email communications may be made a part of my permanent medical record; and (d) email is not an appropriate means of communication regarding emergency or other time-sensitive issues or for inquiries regarding sensitive information. Accordingly, I agree that I will not use email to communicate regarding emergencies or other time-sensitive issues, or to communicate regarding other sensitive information. If I do not receive a response to my email message within two (2) days, I agree I will use another means of communication to contact Hanger Clinic.*