Patient Registration Signature Form

Patient Name _____

I understand that there are some circumstances that may require you to contact me regarding my care. By signing this form, I authorize Hanger Clinic to contact me regarding appointments, treatment instructions, billing/account information or other matters about your care, using the following modes of communication:

Home #: _____ **Work #:** _____ **Mobile/Text * #:** _____ **Email**:** _____

I do not want any voice messages left and/or email: ☐

Revocation of authorization to contact me via email and/or text: I understand that I may revoke my consent for future communications via email and/or text at any time by advising Hanger Clinic in writing. My revocation of authorization will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

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 relationship) _____
- ☐ 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 _____

***Text Communications:** I understand that text message charges from my mobile phone provider may apply. Please be advised that text communication is not always secure. Text messages can be intercepted and, for this reason, we do not communicate personal health information through this method. I will ensure that I keep Hanger Clinic informed of my up-to-date mobile number at all times or if the number is no longer in my possession. Note, texting is only used for appointment reminders and voluntary survey participation requests*

***Email Communications:** (Hanger Clinic utilizes encrypted email when communicating with you about your patient services) 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.*