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 Phone Number _____Work Phone Number _____Mobile Phone Number

We will leave voice messages when available. If you do not want information on any of the following to be left please indicate by initialing.

_____ Appointments
_____ Treatment Instructions
_____ Billing/Account Information
_____ Other (please indicate) _____
_____ I do not want any voice messages left

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

I acknowledge that I have been offered a copy of Hanger Clinic Notice of Privacy Practices, dated March 2014.

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 _____