



**PRE-REGISTRATION INFORMATION**

For Office Use Only

Appointment Date/Time:
LiveOn Physician:

**PATIENT INFORMATION (please print):**

PATIENT NAME LAST FIRST MIDDLE	SOCIAL SECURITY No.	DATE OF BIRTH	SEX
MAIDEN NAME LAST FIRST MIDDLE	EMPLOYER	MARITAL STATUS	
STREET	APT	OCCUPATION (INDICATE IF STUDENT)	
CITY	STATE	ZIP	STREET CITY / STATE / ZIP
HOME PHONE: ( )	BUSINESS / DAYTIME PHONE: ( )	EXT	CELL PHONE: ( ) DRIVER'S LICENSE #

**PERSON RESPONSIBLE FOR BILL (OMIT IF SAME AS PATIENT INFORMATION):**

PATIENT NAME LAST FIRST MIDDLE	RELATIONSHIP	SOCIAL SECURITY NUMBER	D.O.B.
STREET	APT	EMPLOYER	OCCUPATION
CITY	STATE	ZIP	STREET
HOME PHONE: ( )	BUSINESS PHONE: ( )	CITY	STATE ZIP

**EMERGENCY CONTACT – IF RESIDING AT A DIFFERENT ADDRESS (e.g., friend or relative):**

LAST FIRST MIDDLE	RELATIONSHIP
STREET	APT
CITY	STATE ZIP
HOME PHONE: ( )	
BUSINESS DAYTIME PHONE: ( )	

**PLEASE COMPLETE NEXT PAGE**

Live long, live well, live on.

### FINANCIAL INFORMATION

PLEASE BRING INSURANCE CARDS, REFERRAL FORMS (HMOs, POSs, PPOs), OR AUTHORIZATION TO BILL WORKERS' COMPENSATION OR OTHER THIRD PARTY PAYOR.

**PRIMARY INSURANCE:**

PRIMARY INSURANCE CARRIER NAME		POLICY #	GROUP #	COPAY	PLAN TYPE (HMO/PPO)
ADDRESS TO MAIL CLAIMS		SUBSCRIBER'S NAME/DATE OF BIRTH		VERIF. OF BENEFITS PHONE	
CITY	STATE	ZIP	SUBSCRIBER'S SOCIAL SECURITY NUMBER		PRECERTIFICATION PHONE
BEGINNING DATE:	REFERRAL NO. (IF APPLICABLE)	PRECERTIFICATION NUMBER (IF APPLICABLE)		PRIMARY CARE PHYSICIAN	

**SECONDARY INSURANCE:**

PRIMARY INSURANCE CARRIER NAME		POLICY #	GROUP #	COPAY	PLAN TYPE (HMO/PPO)
ADDRESS TO MAIL CLAIMS		SUBSCRIBER'S NAME/DATE OF BIRTH		VERIF. OF BENEFITS PHONE	
CITY	STATE	ZIP	SUBSCRIBER'S SOCIAL SECURITY NUMBER		PRECERTIFICATION PHONE
BEGINNING DATE:	REFERRAL NO. (IF APPLICABLE)	PRECERTIFICATION NUMBER (IF APPLICABLE)		PRIMARY CARE PHYSICIAN	

**IS THIS VISIT DUE TO A WORK RELATED CONDITION?**  Yes  No

**WILL YOU BE USING WORKERS' COMPENSATION INSURANCE?**  Yes  No

EMPLOYER		WORK COMP INSURANCE COMPANY NAME		ADJUSTOR NAME	
STREET		STREET		DATE/DESCRIPTION OF INJURY	
CITY	STATE	ZIP	CITY	STATE	ZIP
PHONE TO VERIFY W/C (    )		W/C INSURANCE PHONE (    )		W/C POLICY NO. CLAIM NO.	

**1. FINANCIAL AGREEMENT**

I hereby assume full responsibility for all charges incurred for professional services rendered by a LiveOn Health Center physician, unless the services are deemed "paid in full" as a result of a contractual agreement between the LiveOn Health Center and my insurer.

**2. AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize LiveOn Health Center to release any medical, psychiatric, infectious diseases (including AIDS confidential information) or drug and/or alcohol related information to my referring physician and any insurance company with whom I have medical benefits for the purpose of filing a medical claim. I acknowledge that this authorization is valid until such time as all medical bills related to my treatment have been paid. I further understand that I can withdraw this consent for release of information at any time prior to this expiration date except to the extent that action has been taken in reliance heron.

**3. CONSENT FOR OBTAINING PRESCRIBED MEDICAL HISTORY**

I hereby authorize LiveOn Health Center to obtain electronically or by other means all of my prescription history. I understand this is important to provide the best medical care.

**4. GROUP & INDIVIDUAL INSURANCE, ASSIGNMENT OF BENEFITS**

I authorize my health insurance benefit plan to pay directly to LiveOn Health Center, the surgical and/or medical benefits. If any, otherwise payable to me for their services as described on attached claim, but not to exceed the charges for those services. I understand I am financially responsible to the Center for charges not covered by this agreement.

**5. MEDICARE, CLAIM AUTHORIZATION AND PAYMENT REQUEST**

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature \_\_\_\_\_ Date: \_\_\_\_\_