PATIENT REGISTRATION FORM
DISCLOSURE & CONSENTS

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

First Name ***M.I*** ***Last Name.***

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to ***THOC, P. A.*** or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that ***THOC, P.A.*** is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID.CHAMPUS INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to ***THOC, P. A.*** or the physician on my behalf.

AUTHORIZATION TO MAIL, CALL OR EMAIL:
I certify that I understand the privacy risks of the mail, phone calls, and email. I herby authorize a ***THOC, P. A.*** representative or my physician to mail, phone calls or email me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the rights to rescind this authorization at any time by notifying ***THOC, P. A.*** to that effect in writing.

LAB/ XRAY/ DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pays or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by my ***THOC, P. A.*** physician or his or her designee.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARANTOR SIGNATURE: _____ **DATE:** _____

GUARANTOR NAME (Please Print) _____