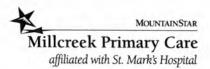


## **Patient Registration Form**

PATIENT INFORMATION  Patient's Name Last	First	(Please Print) Middle
		Apt
		Zip
•		Work Phone
Email Address		
Date of Birth MM/ DD		
Race American Indian or Alaska		- — —
Black or African Americar	 n	lined
Ethnicity Hispanic or Latino	Not Hispanic or Latino De	eclined
Language English Spanish	Other	
Marital Status Married Singl	e Divorced Widowed	Legally Separated Partner
Social Security Number	Em	ployer Name
How did you hear about us?	Existing Patient  Marketing	Google Recommended from family/friend
Recommended from Providence	der (Name)	Insurance Other
EMERGENCY CONTACT INFO	RMATION	
-		First
		Work Phone
Emergency Contact Relationship to	Patient	
RESPONSIBLE PARTY INFOR	MATION	(information used for patient balance statements
Check here if information is same		(illionidatori doca foi pationi salarios etatorilenti
	_	First
Date of Birth MM/ DD		
		Apt
		Zip
		ployer Name
Email Address		
Liliali Addiess		
I agree that the information suppl	ied on this form is accurate	and up-to-date to the best of my knowledge
Patient (or Responsible Party) Sig	anature	Date



## **Patient Consent Form**

## Consent to Medical Services

I consent to laboratory procedures or other services rendered to me as ordered by my physician. This consent includes the testing for blood-borne infectious diseases, including but not limited to Hepatitis and HIV (Human Immune Deficiency), a physician orders such tests diagnostic purposes.

## **Assignment of Benefits**

This assignment of benefits allows the healthcare facility and/or facility-based physicians to be paid directly by my health insurance carrier or other health benefit plan for the laboratory services, the healthcare facility and/or facility-based physicians provide to me. In return for the services rendered and to be rendered by the facility and/or facility based physicians provided to me. In return for the services rendered and to be rendered by the facility and/or facility-based physicians all right, title, and interest in all benefits payable for the laboratory services rendered, which are provided in any and all insurance policies and health benefit plans form which my dependents or I are entitled to recover. This assignment and transfer shall be for the purpose of granting the healthcare facility and/or facility-based physicians an independent right of recovery against my insurer or physicians to pursue any such right or recovery. In no event will the healthcare facility and/or facility based physicians retain benefits in excess of the amount owed to the healthcare facility and/or facility-based physicians for the care and treatment rendered during my visit(s).

**Payment Agreement** The patient/responsible party or legal guardian obligates himself to the payment of practices account incurred in accordance with the regular rates and terms of the practice at time of discharge. If the patient/ responsible party fails to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, the patient/responsible party shall pay a 29% collection fee and all court costs and attorney's fees.

**Medicare Patient Certification** I certify that the information given by me in applying the payment under Title XVII of Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers 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 authorized benefits be made on my behalf.

I hereby certify and state that I have read and been given the opportunity to ask questions about this Patient Authorization, I fully understand this Patient Authorization and that I have signed this Patient Authorization knowingly, freely, and voluntarily. Moreover, I certify and state that I have received no promises, assurances or guarantees from anyone as to the results that may be obtained by any Laboratory procedure or other services and I have signed this document without inducement, other than the rendition of services by the healthcare facility and/ or facility-based physicians.

Patient/Parent/Guardian/Conservator Signature	Relationship to Patient	Date
Print Patient Name		
X		
Witness Signature	Print Name	Date