Language Learning Associates - Patient Registration Form

Date ____________________

PATIENT INFORMATION *(Please write information about the patient here)*

PATIENT'S NAME (Last, First, Middle Initial)		PARENT/GUARDIAN DAYTIME PHONE ( )	PARENT/GUARDIAN CELL PHONE ( )
PATIENT'S ADDRESS			
CITY STATE ZIP			
TELEPHONE ( )	DATE OF BIRTH / /	REFERRING DOCTOR	
SOCIAL SECURITY NUMBER - -		REFERRING DOCTOR ADDRESS CITY STATE ZIP	

INSURANCE INFORMATION *(Please write information about the patient's insurance here)*

PRIMARY INSURANCE COMPANY NAME		SECONDARY INSURANCE COMPANY NAME
INSURANCE COMPANY'S ADDRESS		INSURANCE COMPANY'S ADDRESS
CITY STATE ZIP		CITY STATE ZIP
INSURED'S ID NUMBER GROUP PLAN NUMBER		INSURED'S ID NUMBER GROUP PLAN NUMBER
EMPLOYER PLAN COVERAGE I ☐ YES ☐ NO	IF CHAMPUS: ☐ Active ☐ Retired ☐ Deceased Branch of Service: ________________	

POLICYHOLDER INFORMATION

(Complete the information below if the PATIENT is NOT the POLICYHOLDER)

PRIMARY POLICYHOLDER'S NAME (Last, First, Middle Initial)		SECONDARY POLICYHOLDER'S NAME (Last, First, Middle Initial)	
DATE OF BIRTH / /	SEX ☐ Male ☐ Female	DATE OF BIRTH / /	SEX ☐ Male ☐ Female
PRIMARY POLICYHOLDER'S ADDRESS		SECONDARY POLICYHOLDER'S ADDRESS	
CITY STATE ZIP		CITY STATE ZIP	
TELEPHONE ( )		TELEPHONE ( )	
MARITAL STATUS: ☐ Separated ☐ Single ☐ Divorced ☐ Married ☐ Widowed		EMPLOYER'S NAME	
EMPLOYERS NAME		EMPLOYER'S ADDRESS	
CITY STATE ZIP		CITY STATE ZIP	
SOCIAL SECURITY NUMBER - -	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER - -	RELATIONSHIP TO PATIENT
		EMPLOYER PLAN COVERAGE ☐ YES ☐ NO	IF CHAMPUS:☐ Active ☐ Retired ☐ Deceased Branch of Service: ________________

RESPONSIBLE PARTY INFORMATION

(Please complete the information below if the person responsible for paying the bill is not the PATIENT or the POLICYHOLDER)

RESPONSIBLE PARTY'S NAME (Last, First, Middle Initial)	SEX ☐ Male ☐ Female	SOCIAL SECURITY NUMBER - -
RESPONSIBLE PARTY'S ADDRESS STATE	ZIP	EMPLOYER'S NAME TELEPHONE ( )
TELEPHONE ( ) RELATIONSHIP TO PATIENT		EMPLOYER'S ADDRESS STATE ZIP

I CONSENT TO TREATMENT AND AGREE TO THE ASSIGNMENTS AND FINANCIAL RESPONSIBILITIES SHOWN ON THE BACK OF THIS FORM. <u>YOU SHOULD READ THOSE TERMS CAREFULLY.</u>

X ____________________________________ Date ____________

SIGNED (Patient, or parent if under 18 years of age.)

Please remember that insurance is considered a method of reimbursing the patient for fees paid to LLA and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

In order to control your cost of billings, we request that our charges for office visits be paid at the conclusion of each visit.

If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including medicare, private insurance and other health plans to the practice named on the other side of this form.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

THANK YOU FOR YOUR COOPERATION

Language Learning Associates