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Harmony Healthcare

PATIENT REGISTRATION FORM

(Please complete in black ink only)

Client #_____

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Home #	Work #	Cell #
Email address:				Date of Birth	Age
Address	City	State ZIP	Sex (circle one) Male ☐ Female ☐		Social Security #
Marital Status	Employer/School	Address		Occupation	Department
Emergency Contact (Other than someone that lives with you)				Phone #	

RESPONSIBLE PARTY/GUARDIAN (Individual signing this form)

Last Name	First Name	Middle Initial	Home #	Work #	Date of Birth
Address	City	State ZIP	Sex (circle one) Male ☐ Female ☐	Marital Status	Social Security #
Employer	Employer's Address		Occupation	Department	Relationship to Patient

INSURED PARTY INFORMATION (Spouse or Parent if different from Responsible Party)

Last Name	First Name	Middle Initial	Home #	Work #
Employer	Employer's Address			Date of Birth
Relationship to Patient	Occupation	Department		Social Security #

PRIMARY INSURANCE INFORMATION

Insurance Company Name	Claims Mailing Address City State ZIP		Phone #
ID#	Group Name and Number	Insured Party	Date of Birth
Effective Date	Deductible/Copay Information	Deductible Met?	Relationship to Patient

SECONDARY INSURANCE INFORMATION

Insurance Company Name	Claims Mailing Address City State ZIP		Phone #
ID #	Group Name and Number	Insured Party	Date of Birth
Effective Date	Deductible/Copay Information	Deductible Met?	Relationship to Patient

I HEREBY GUARANTEE PAYMENT FOR THE ENTIRE BALANCE OF THE ABOVE-NAMED PATIENT. I AUTHORIZE TREATMENT OF THE ABOVE-NAMED PATIENT. I ASSIGN AND AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO HARMONY HEALTHCARE AND/OR ITS REPRESENTATIVES. I AUTHORIZE RELEASE OF ANY INFORMATION, INCLUDING CONFIDENTIAL MEDICAL RECORDS, REQUESTED BY INSURANCE COMPANIES, PAYORS, OR GOVERNMENT AGENCIES IN CONNECTION WITH THIS ASSIGNMENT. TO CANCEL AN APPOINTMENT, THE ABOVE-NAMED PATIENT MUST NOTIFY HARMONY HEALTHCARE AT LEAST 24 HOURS PRIOR TO THE SCHEDULED APPOINTMENT TIME, OR ELSE I WILL BE RESPONSIBLE FOR PAYING A $50.00 CANCELLATION FEE. IF THE ABOVE-NAMED PATIENT FAILS TO ATTEND AN APPOINTMENT, I WILL BE RESPONSIBLE FOR PAYING A $50.00 MISSED-APPOINTMENT FEE. I HAVE READ, UNDERSTAND, AND AGREE TO THE DESCRIBED DISCLOSURE, FINANCIAL POLICY, AND VARIOUS RELEASES AND GUARANTEES.

SIGNATURE OF RESPONSIBLE PARTY: _____ DATE: _____

By typing your full name electronically on this page, you are agreeing that your electronic signature is the legal equivalent of your manual signature.

HARMONY HEALTHCARE
PATIENT ACKNOWLEDGMENT OF NOTICES

Pt's Name: _____
MR#:_____
Treating Provider: _____

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

Each year Harmony Healthcare is required to obtain updated signature approval from our clients. By initialing each line I agree that I have read, understand and agree to the terms of each notice.

Notices

_____ Notice of Privacy Practices _____ Patient Bill of Rights

_____ Consent for Treatment _____ Consent for Intern _____ Financial Responsibility

☐ I have received a copy of the Notice of Privacy Practices, Bill of Rights, Consent for Treatment, Consent for Intern and Financial Responsibility _____ (initial)

☐ I **do not** need a copy of the Notice of Privacy Practices, Bill of Rights, Consent for Treatment, Consent for Intern and Financial Responsibility _____ (initial)

Patient Registration Annual Update

I confirm that I have reviewed the personal and insurance information on file for _____ _____(patient name) and confirm all information is accurate.

I hereby guarantee payment for the entire balance of the above-named patient. I authorize treatment of the above-named patient. I assign and authorize payment of medical benefits directly to Harmony Healthcare and/or its representatives. I authorize release of any information, including confidential medical records, requested by insurance companies, payors, or government agencies in connection with this assignment. I have read, understand, and agree to the described disclosure, financial policy, and various releases and guarantees.

SIGNATURE OF RESPONSIBLE PARTY: _____ DATE: _____

No Show / Late Cancelation Appointment Notice

I understand that I am responsible to notify Harmony Healthcare at least 24 hours prior to the scheduled appointment time to cancel or reschedule the scheduled appointment for the above named patient, or else I will be responsible for paying a $50.00 cancellation fee. If the above-named patient fails to attend an appointment, I will be responsible for paying a $50.00 missed-appointment fee.

Authorizations

I understand that Harmony Healthcare is unable to provide information regarding myself or my account without my consent.

I authorize _____ who is _____(***relationship to client***) to be able to call Harmony Healthcare to Schedule, Re-Schedule, Confirm or Cancel my appointments.

I authorize _____ who is _____(***relationship to client***) to be able to call Harmony Healthcare to inquire and speak to the staff in the Billing Department regarding my account.

_____ _____
Client Signature Date Legal Guardian (if applicable) Date

_____
Witness Signature Date