Mitchel G. Katz, MD *Connecticut & Gulf Coast ADHD Associates*

Patient Registration Form

Patient Demographics

Name: _____ Date of Birth:_____M/S___
Address: _____ SSN: _____
City: _____ State: _____ Zip: _____
Home Phone _____Cell Phone: _____E-mail_____
How did you hear about us? _____

In case of an emergency:
Contact # 1: _____
Relationship: _____
Home Phone _____

In case of an emergency:
Contact # 2: _____
Relationship: _____
Home Phone: _____

Employment Information
Employer Name: _____ Phone: _____
Employer Address: _____ City: _____
State: _____ Zip: _____ Occupation: _____

Guarantor Information (person financially responsible)

Name: _____DOB:_____ Relationship: _____
Address: _____ SSN: _____
City: _____ State: _____ Zip: _____
Home Phone _____ Cell Phone: _____
Employer Name: _____ Phone _____
Employer Address: _____ City: _____
State: _____ Zip: _____

Assignment of Benefits

I request that payment of authorized insurance benefits, be made on my behalf or my child's behalf to MITCHEL G. KATZ MD LLC for any medical services provided to me by that practice.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the practice, the Health Care Financing Administration, my or my child's insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my (or my child's) insurance company or other entity of requested. The original will be kept on file.

I understand that I am financially responsible to the practice for any charges not covered by health care benefits.

I acknowledge that in some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I agree to be responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services received.

By signing this document I also acknowledge that I have received a copy of the practice's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my (or my child's) privacy rights.
Name of person signing _____ Relationship to insured_____

Signature of Insured or Parent/Guardian_____Date_____