TMLB

Patient Registration Signature Form

I understand there are some circumstances that may require Tony Martin Limb and Brace to contact me regarding my care. By initialing and signing below, I authorize Tony Martin Limb and Brace to contact me via Voicemail, Text or Email at the following

Text Message Email Address Voicemail

We will leave voice messages, send text or email when available. If you do not want information on any of the following to be left please indicate by checking.

Appointments

Billing/Account Information

None

Treatment Instructions

Other (Please Indicate)

I authorize Tony Martin Limb and Brace to share information regarding my treatment or payment for treatment, with the following individuals:

My Spouse or Partner (name)

My son or daughter (name)

Other individual (name)

None

I acknowledge that I have been offered a copy of the Tony Martin Limb and Brace Notice of Privacy practices, dated January 2015.

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Tony Martin Limb and Brace for any covered services furnished by Tony Martin Limb and Brace. I agree to pay to Tony Mart'in Limb and Brace the deductible and/or coinsurance on my claim.

I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents Char pus/TRICARE and its agents, or to any private insurance company any information needed to determine these benefits or the benefits payable for related service.

X Date

Signature of Patient or Responsible Party

X Date

Signature of Representative (acknowledging receipt only)

Relationship to Patient

X Date

Signature of Witness (if patient signing with a mark)

Printed Name of Representative or Witness

Address of Representative or Witness

Reason for Patient's inability to Sign