PATIENT REGISTRATION SIGNATURE FORM

Patient Information

Patient Name: (Last/First MI) ____ Date of Birth: ______ / ______ / ____________

Responsible Party Name: (Last/First MI) ____

Relationship to Patient: ____

Authorizations and Acknowledgements

I have received the Notice of Privacy Practices from Family Achievement Center, Inc.

Signature: ____ Date: ______ / ______ / ____________
Parent / Legal Guardian / Self

I hereby authorize FAMILY ACHIEVEMENT CENTER to furnish information concerning my illness and treatments to INSURANCE CARRIERS, PHYSICIANS, THERAPISTS, AND/OR OTHER PERSONNEL, who are involved in taking care of the patient. I authorize payment of any medical benefits to FAMILY ACHIEVEMENT CENTER. **I certify that the information completed on the patient registration form is correct and that I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED.** I permit a copy of this authorization to be used in place of the original.

Signature: ____ Date: ______ / ______ / ____________
Parent / Legal Guardian / Self

-- **MEDICARE PATIENTS** --

Medicare Authorization: I request that payment of authorized medical benefits be made on my behalf to FAMILY ACHIEVEMENT CENTER for services furnished me by this clinic/physician/supplier. I authorize any holder of hospital or medical information about me be released to the HEALTH CARE FINANCING ADMINISTRATION and it's agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Signature: ____ Date: ______ / ______ / ____________
Parent / Legal Guardian / Self

MediGap Authorization: I request that payment of authorized Medigap benefits be made on my behalf to FAMILY ACHIEVEMENT CENTER for any services furnished me by this clinic/physician/suppler. I authorize any holder of medical information about me to release to ____________________________________ any information needed to determine these benefits or the benefits payable for related services.

Signature: ____ Date: ______ / ______ / ____________
Parent / Legal Guardian / Self

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