REGISTRATION

Date ____________________ Left handed ____ Right Handed _____

Last Name ____ First ________________________________MI ____________________

Address ________________________________ City __________________________State __________ ZIP ________________________

Cell Phone (__)_____________Home Phone (___)____________ Work Phone (___)____

Date of Birth _________________ Age ______ SSN# ____Marital Status ____________________

Employer ___________________________Occupation __________________ Address ____

Whom may we thank for referring you? ____

Policy Holder Insurance Information

Insurance ID Number _________________________________ Insurance Company Name ____

Policy Holder Name ____ Relationship to Patient ______________________________

Policy Holder Address____________________________________ City ______________________ State___________ Zip _________________

Policy Holder Address Phone Number: _________________________DOB _______________SSN#____________________________________

Group # ________________Insurance Address _____________________________________ Insurance Phone Number __________________

Policy Holder Employer Name ____

Employer Address____ Occupation ____

City _______________________________ State ___________________________ Zip ____

You are responsible for providing our office with the most current information. All balances from incorrect information will be billed to you.

Secondary Insurance ____

Address ____

ID# ____ Group # _______

Name of Insured _______________________________________Relationship to Patient ____

Primary Care Physician

Name ____ Phone ( ) ____

Address ____

Outside(Emergency) Contact: Name ______________________________Phone___________________________Relationship________________

Insurance Authorization and Assignment: I request the payment of authorized benefits be made in my behalf to Marnin E. Fischbach, M.D. P.C. for any services furnished me by that physician. I authorize release of any medical information necessary to process my claim. I understand that I am responsible for all charges regardless of insurance coverage. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services. I have reviewed the Notice of Privacy Practices which describes how my health information may be used or disclosed, and affirm that this is clear to me and I understand all of it.

Signature____Date ____

Revised 01/15

Marnin E. Fischbach, M.D., P.C.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Our commitment to your privacy:

This practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private.

We will use the information about your health, which we get from you or from others, to provide you with treatment, to arrange payment for our services, and for some other business activities which are called, in the law, health care operations. After you read this NPP, we will ask you to sign an Authorization Form to let us use and share your information.

If we or you want to use or disclose (send, share, release) your information for any other purposes, we will discuss this with you and ask you to sign an Authorization form to allow this.

Of course we will keep your health information private, but there are some circumstances when the laws require us to use or share it. For example:

1) When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person/organization that is able to help prevent or reduce the threat, or the person who is in danger.

Court orders, some lawsuits and legal or court proceedings.

2) If a law enforcement official requires us to do so.
3) I understand that I can revoke or cancel this authorization at any time by sending a signed letter to Dr. Fischbach at his address. If I do this, it will prevent any releases after the date it is received, but not change the fact that some information may have been sent or shared before that date.
4) I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Dr. Fischbach, nor will it affect my eligibility for benefits.
5) I understand that I may inspect and have a copy of the health information described in this authorization.
6) I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may no longer protected by those regulations.
7) I affirm that everything in this form is clear to me, and I understand all of it.

____ ____________________
Signature of client or his or her personal representative Date

____ ____________________
Printed name of client or personal representative Relationship to the Client

____
Description of personal representative's authority

8) I, a mental health professional, have discussed the issues with the client and his or her personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willingly consent.

________________________________ __________________________________ _________________
Signature of professional Printed name of professional Date

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