

Patient Registration Signature Form

Patient Name _____

I understand that there are some circumstances that may require you to contact me regarding my care. By initialing and signing below, I authorize At Last...Bra & Lingerie to contact me at the following (please initial all that apply):

_____ Home Phone Number _____ Work Phone Number _____ Cell Phone Number

We will leave voice messages when available. If you do not want information on any of the following to be left please indicate by initialing.

_____ Appointments
 _____ Treatment Instructions
 _____ Billing/Account Information
 _____ Other (please indicate) _____
 _____ I do not want any voice messages left

I authorize At Last...Bra & Lingerie 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 At Last...Bra & Lingerie Notice of Privacy Practices, dated October 2016.

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to At Last...Bra & Lingerie or any of its subsidiaries for any covered services furnished by At Last...Bra & Lingerie. I agree to pay to At Last...Bra & Lingerie the deductible and/or coinsurance on my claim.

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

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: _____