GEORGETOWN SLEEP

REGISTRATION FORM

(Please Print)

Today's date:	Email:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Home Phone #	Cell phone #	Additional phone #	Best time to reach during day:	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Birthdate:

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

INSURANCE INFORMATION

Primary Insurance Company Name:	ID Number on front of card:	Group number on front of card:

Name of insured (if other than patient):	Insured's birthdate(if other than patient)	Insured's Social Security No. (if other than patient)	Patient's relationship to insured:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

INSURANCE ASSIGNMENT AND RELEASE/RECEIPT OF PRIVACY PRACTICES

I certify that I (and/or my dependents) have insurance coverage with _____and assign directly to Georgetown Sleep all insurance benefits, if any otherwise payable to Georgetown Sleep for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Georgetown Sleep may use my healthcare information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

FOR MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits, and if applicable Medigap benefits, be made to Georgetown Sleep for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have read in full and/or received a copy of Georgetown Sleep's privacy practices.

_____

Signature of Beneficiary, Guardian, or Patient Representative

_____

Date