Northwest Wellness Center

Patient Registration (PLEASE PRINT) **Email:**___________________________

Date_____________________ Home Phone _______________________ Cell Phone ______________________

Patient____
Last Name First Name Initial

Street Address ____

City _________________________________ State __________________ Zip __________________

Patient Social Security Number ______________________ Sex ☐ M ☐ F Age ________ Birth Date ____________

Patient Employed By ____

Business Address ____

Occupation ______________________________________ Business Phone __________________

Primary Care Physician Name __________________________________ Phone Number __________________

Referred by ____ Phone Number __________________

Responsible Party Information (if not the patient)

Full Name ______________________________________ Relationship to Patient __________________

Social Security Number ____________________________ Birth Date __________________________

Business Name ____

Business Address ____

Occupation ______________________________________ Business Phone __________________

Emergency Contact Information

Full Name ______________________________________ Relationship to Patient __________________

Business Phone __________________________ Alternate Phone ____________________________

Do you have Medical Insurance ☐ Yes ☐ No **If yes:** ☐ Medicare ☐ Medicaid (public aid) ☐ Commercial ☐ Work Comp ☐ Auto

Name of Primary Insurance Company (and Contact if needed) _____________________________________

Member ID / Claim # __________________________________ Group # ____________________________

Name of **Secondary** Insurance Company (if any) ____

Member ID / Claim # __________________________________ Group # ____________________________

CONSENT FOR TREATMENT

I, as the patient/guardian, authorize Northwest Wellness Center/Rehabilitation Associates and its medical professionals to treat me or the minor patient named in the above registration.

I intend this consent form to cover the entire course of treatment for the present condition and for any future condition(s) for which I or the minor patient will seek treatment with Northwest Wellness Center/Rehabilitation Associates.

INSURANCE AUTHORIZATION (We will bill your insurance on your behalf.)

I, the undersigned have insurance coverage with ____
Name of Insurance Company(s)

and I authorize my insurance benefits be paid directly to Northwest Wellness Center/Rehabilitation Associates or its medical professionals. I hereby authorize Northwest Wellness Center/Rehabilitation Associates to release any and all information necessary *(including mental health records)* to the insurance company(s) in order to process my claims and secure the payment. I authorize the use of this signature on any and all of my insurance submissions. **I understand that I am financially responsible for any and all charges not paid by my insurance(s).**

____ ______________________________
Signature of Insured / Guardian / Responsible Party (age 18 or older) Date