Registration Form

☐ New ☐ Revision 01/01/15

DATE	REFERRING PHYSICIAN'S FULL NAME	PHONE NUMBER	PRIMARY CARE PHYSICIAN	
PATIENT NAME (Last) (First) (Middle)			DATE OF BIRTH	GENDER
STREET ADDRESS				SOCIAL SECURITY NUMBER
CITY	STATE	ZIP CODE		HOME PHONE NUMBER
EMPLOYER	ADDRESS			BUSINESS PHONE NUMBER

EMERGENCY CONTACT INFORMATION

PERSON to CONTACT in CASE of EMERGENCY	RELATIONSHIP TO PATIENT	HOME PHONE NUMBER	BUSINESS PHONE NUMBER

INSURANCE SUBSCRIBER INFORMATION

RESPONSIBLE PARTY/SUBSCRIBER'S NAME	RELATIONSHIP TO PATIENT	HOME PHONE NUMBER	DATE OF BIRTH
STREET ADDRESS			SOCIAL SECURITY NUMBER
CITY	STATE	ZIP CODE	
EMPLOYER	ADDRESS		BUSINESS PHONE NUMBER

3. Name of your PRIMARY health care coverage _____
   Member ID# _____ Group # _____
   Subscriber's name _____
   Subscriber's date of birth _____ Subscriber's SS# _____

4. If covered by Medicare, do either you or your spouse work? ☐ Yes ☐ No
   If yes, does the employer provide health insurance coverage? ☐ Yes ☐ No
   Employer's Name _____ Phone # _____
   Employer's Address _____
   Name & Address of Insurance _____
   Policy # _____ Group # _____ Subscriber _____
   Are there over 20 employees? ☐ Yes ☐ No

5. Do you have SECONDARY health insurance coverage? ☐ Yes ☐ No
   If yes, name of Insurance Company _____
   Policy # _____ Group # _____ Subscriber _____
   Subscriber's date of birth _____ Subscriber's SS# _____

ATTACH COPIES OF ALL CORRESPONDING INSURANCE CARDS FRONT & BACK

MEDICARE BENEFICIARY AUTHORIZATIONS

_____ _____

Name of Beneficiary | Medicare ID Number

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to _____ for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration, and its agents, any information needed determine these benefits or the benefits payable for related services."

_____ _____

Beneficiary Signature | Date

MEDIGAP *(Medicare Patients Only)*

"I authorize payment of Medical benefits to be paid directly to **ABS Medicine LLC, Alyson B. Simpson MD** for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to my insurance carrier any information needed to determine these benefits payable for related services."

_____ _____

Beneficiary Signature | Date

RELEASE OF MEDICAL BENEFITS AND RECORDS

"I authorize payment of Medical benefits to ABS Medicine LLC for services rendered.

_____

Name of Patient

I understand that services are rendered to me and not to the insurance carrier on my behalf. The insurance carrier will not relieve me from my financial responsibility to **ABS Medicine LLC, Alyson B. Simpson MD.** I hereby authorize said assignee to release all information necessary to secure payment of said benefits."

_____ _____

Signature of Responsible Party | Date