Dr Elizabeth Collins
NATUROPATHIC PHYSICIAN

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PATIENT REGISTRATION

PERSONAL INFORMATION

Patient Name			
Address			
City, State, Zip			
Home Phone		Cell Phone	
Date of Birth	Age	Gender	Pronouns
Spouse/Partner Name			

PRIMARY INSURANCE CARRIER

Primary Insured's Name	
Date of Birth	
Employer	
Identification Number	Group Number

SECONDARY INSURANCE CARRIER

Primary Insured's Name	
Date of Birth	
Employer	
Identification Number	Group Number

Referred by:

RELATIVE OR FRIEND WE MAY CONTACT IN AN EMERGENCY

Emergency Contact Name	
Address	
City, State, Zip	
Home Phone	Cell Phone

I understand that I am financially responsible for payment of this account and/or charges not covered by my insurance.

Signature _____

I understand that the above provider will use and disclose health information about me as outlined in this notice of privacy practices. I understand that this information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of related information.

I understand and agree that these providers may use and disclose my health information as outlined in this notice in order to:

1. Make decisions about and plan for my care and treatment;
2. Refer to, consult with, coordinate among, and manage along with other care providers for my care and treatment;
3. Determine my eligibility for health plan or insurance coverage and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
4. Perform various office, administrative, and business functions that support my care provider's efforts to provide me with, arrange, and be reimbursed for quality, cost-effective care.

By signing below, I agree to be seen as a patient by this provider and I verify that I have received, reviewed and understand the information contained in the NOTICE OF PRIVACY PRACTICES.

I am giving my permission to call my home/ cell phone (circle preference) to remind me of appointments. ☐ YES ☐ NO

I am giving my permission to call my home/ cell phone (circle preference) regarding lab results or messages from my doctor ☐ YES ☐ NO

I am giving my permission for my doctor to leave important medical information with other family member(s):

Family Member's Name	Relationship

Signature _____ *Date* _____

Printed Name _____