CENTER FOR SYMPTOM RELIEF, LLC
3600 OLENTANGY RIVER RD SUITE C-2 & C-3
COLUMBUS, OH 43214
PH: 614-459-0350 FAX: 614-459-0355

REGISTRATION FORM

Today's date:					PCP:	
PATIENT INFORMATION						
Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M	❑ F
Street address:		Social Security no.:			Home phone No:	
P.O. box:	City:	State:	ZIP Code:			
Occupation:	E-mail:	Alternate Phone No:				
Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.		❑ Insurance Plan	❑ Hospital		
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other		
Other family members seen here:						
Primary Care Physician:		Phone No. ( )				
Referring Physician:		Phone No. ( )				
Pharmacy:		Phone No. ( )				
Spouse's last name: First:		Birth date: / /				
Social Security no:		Phone No. ( )				
Employer:		Employer's Phone No. ( )				
INSURANCE INFORMATION						
Please give your insurance card and photo ID to the receptionist. You must notify us if this is an accident or work related visit.						
Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:			
Is this person a patient here? ❑ Yes ❑ No						
Occupation:	Employer:	Employer address:	Employer phone no.:			
Is this patient covered by insurance? ❑ Yes ❑ No						
Subscriber's name:	Subscriber's S.S. no:	Birth date:	Group no:	Policy no:	Co-payment:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		
Name of secondary insurance (if applicable):	Subscriber's name:	Group no:	Policy no:			
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

AUTHORIZATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION:

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT , NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVCIES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. ALL COPAYS ARE PAYABLE AT THE TIME OF SERVICE.

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I HERBY AUTHORIZE THE CENTER FOR SYMPTOM RELIEF, LLC TO FURNISH INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONERNING MY (MY DEPENDENTS) ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE CENTER FOR SYMPTOM RELIEF, LLC ALL PAYMENTS FOR MEDICAL SERVICES RENDERED BY MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

I HEREBY AUTHORIZE AND RELEASE THE DOCTOR AND WHOMEVER HE/SHE MAY DESIGNATE AS HIS/HER ASSISTANT TO ADMINISTER TREATMENT, PHYSICAL EXAM, X-RAY STUDIOS, LABORATORY PROCEDURES, MEDICAL CARE OR ANY CLINICAL SERVICE THAT HE/SHE DEEMS NECESSARY IN MY CASE, AND I FURTHER AUTHORIZE HIM/HER TO DISCLOSE ALL OR PART OF MY (PATIENTS) RECORD TO ANY PERSON OR CORPORATION WHICH IS OR MAY BE LIABLE UNDER CONTRACT TO THE CLINIC OR TO THE PATIENT OR TO A FAMILY MEMBER OR EMPLOYER OF THE PATIENT FOR ALL OR PART OF THE CLINIC CHARGE, INCLUDING BUT NOT LIMITED TO HOSPITAL OR MEDICAL SERVICES COMPANY, INSURANCE COMPANY, WORKERS COMPENSATION CARRIERS, WELFARE FUNDS, OR THE PATIENTS EMPLOYER.

HIPPA ACKNOWLEDGEMENT:

I HAVE RECEIVED AND HAVE READ THE CENTER FOR SYMPTOM RELIEF, LLC NOTICE OF PRICACY PRACTICES.

IN MY ABSENCE OR FOR THE BENEFIT OF GAINING MEDICAL ADVICE ON MY BEHALF, I AUTHORIZE THE FOLLOWING PERSON TO GAIN PAITENT HEALTH INFORAMTION FOR OR WITH ME: _____

(Please list authorized Representative (s) or mark N/A

Patient/Guardian signature _____ *Date* _____

Additional Questions: Please circle one that applies

1. **Race:** American Indian or Other Pacific

   Black or Native American

   White

   Hispanic

   Other Race

   Other Pacific Islander

2. **Ethnicity:** Hispanic or Latin

   Not Hispanic or Latin