

The Langsdon Clinic

7499 Poplar Pike
Germantown, TN 38138

REGISTRATION FORM / PRIVACY NOTICE SIGNATURE

Patient Name

Date of Birth

Street Address, City, State, Zip Code

Employer Name

Occupation

Employer Address, City State, Zip Code

Employer Phone Number

A.

PATIENT RESPONSIBILITES: I understand that as the patient, parent or guardian, I am legally responsible for payments of all charges relating to my care. Patient and/or guarantor(s) agree to pay reasonable attorney's fee and cost of collection if patient's account is placed in the hands of an attorney for handling.

PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act, or under other insurance coverage, is correct. I authorize any holder of medical or other information about me to release to S.S.A. or its intermediaries or carriers and/or the State in which I reside or Fiscal Agents, or the insurance company or its representatives, any information needed for this or a related Medicare/Medicaid claim or other insurance claim. In consideration of services rendered, I transfer and assign to Phillip R. Langsdon, M.D. any payment which may become due to me for medical and/or surgical services under policies applicable to me or my dependent.

B.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide The Langsdon Clinic with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Name print)

Patient's Signature

Date

Or Guarantor Signature

Date