

# NRC DNP Telehealth LLC

Confidential

Registration Information

Please Print

New Patient  
 Existing Patient

**Existing Patient:** Revise all information that has changed since your last visit

Date \_\_\_/\_\_\_/\_\_\_ Email Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ Mailing Address \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Gender: Male \_\_\_ Female \_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth-date \_\_\_/\_\_\_/\_\_\_

Circle One: Married - Single - Partnered – Widowed Name of Partner/Spouse/Significant Other \_\_\_\_\_

Patient Employed by: \_\_\_\_\_

Business Address \_\_\_\_\_

Business Phone: \_\_\_\_\_ Occupation \_\_\_\_\_

Name of Spouse/Responsible Party (If patient is minor): \_\_\_\_\_  
Last First MI

Spouse/Responsible party Employed by: \_\_\_\_\_

Business Address: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Occupation \_\_\_\_\_

Responsible Party/Spouse SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Do you have medical Insurance? Circle One: No Yes If yes, please fill in the following information:

Name of Primary Insurance: \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

\*Subscriber's Name: \_\_\_\_\_ \*Birth-date: \_\_\_/\_\_\_/\_\_\_

Insurance Address \_\_\_\_\_

Name of Secondary Insurance: \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

\*Subscriber's Name: \_\_\_\_\_ \*Birth-date: \_\_\_/\_\_\_/\_\_\_

Insurance Address \_\_\_\_\_

\*This information is required by HIPPA

In case of an emergency, who should be notified? \_\_\_\_\_

Relationship \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

### Assignment of Insurance Benefits

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and even claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I \_\_\_\_\_ hereby authorize \_\_\_\_\_  
(Name of Insured) (Name of Insurance Company)

to pay and hereby assign directly to Dr. Natalie Roye all benefits, if any, otherwise payable to me for his/her  
(Provider's Name)

services as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Dr. Natalie Roye  
(Provider's Name)

will be credited to my account, in accordance with the above said assignment.

\_\_\_\_\_  
(Authorized Signature of Subscriber)

\_\_\_\_\_  
(Date)

### Medicare Authorization

IF YOU ARE COVERED BY MEDICARE, PLEASE SIGN AND DATE BELOW

I request payment of authorized Medicare benefits be made either to me or on my behalf to [Your name, Practice Name], are for any services furnished to me by [practice name]. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the health care provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services, Co-Insurance and the deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_  
Signature of Beneficiary

\_\_\_\_\_  
Date

### Financial Policy

I have read and understand the financial policies of NRC DNP Telehealth LLC. By my signature I agree to the terms outlined in the financial policies.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### Consent for Treatment

I (or my legal guardian/parent) authorize NRC DNP Telehealth LLC to provide medical care reasonable by today's standards.

\_\_\_\_\_  
Signature of Patient/Legal Guardian

\_\_\_\_\_  
Date