REGISTRATION FORM

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____

ADDRESS: _____ APT#/FL: _____

CITY: _____ STATE: _____ ZIP: _____

PRIMARY PHONE: _____ SECONDARY PHONE: _____

BIRTH DATE: _____ SOCIAL SECURITY NUMBER: _____-_____-_____

EMAIL ADDRESS: _____

MARITAL STATUS: (Please circle one) *SINGLE, MARRIED, DIVORCED, WIDOWED* SEX: *MALE, FEMALE, OTHER*

EMPLOYER: _____ EMAIL: _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE: _____

PRIMARY PHARMACY: _____ PHONE: _____

ARE YOU INTERESTED IN: ☐ **Weight loss** ☐ **Hair Removal** ☐ **Botox/Anti-Aging** ☐ **Hair Re-Growth**

CURRENT INSURANCE INFORMATION:

PRIMARY: _____ ID#: _____ GROUP#: _____

SECONDARY: _____ID#: _____ GROUP#: _____

All professional services rendered by CareMedica is the responsibility of the patient set forth by their insurance carrier. If the patient feels to remit payments, disclose proper insurance information and/or does not list a CareMedica provider as their Primary Care Provider; patient will be turned over to collections. When an account is turned over to collections, the patient is responsible for any bills, interest and attorney fees incurred. **AUTHORIZATION OF PAYMENT:** I hereby authorize payment directly to the rendering Physician and/or CareMedica for services provided. **AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize my rendering provider and/or CareMedica to release any information required from my examination and/or treatment to my insurance company for payment of services or to another provider for continuation of medical care. **MEDICARE STATEMENT (if applicable):** Claims will be submitted to Medicare for you by CareMedica. Medicare may not cover some services in which the patient may be responsible to pay if no other supplemental policy exists. Such identified services may include yearly physicals etc. In addition, you will be responsible to pay for your Annual Medicare deductible and coinsurance set forth by Medicare if you have chosen a supplemental policy to Medicare then it might cover your balance based on the coverage.

SIGNATURE: _____ DATE: _____