MANCHESTER-BEDFORD MYOSKELETAL

Office Use Only
Acct # MB-

Rev. 5 (10/2024)

PATIENT INFORMATION

Name: _____ Date of Birth: _____
(First, MI, Last) *(mm/dd/yyyy)*

Sex: F M Marital Status: Choose One Occupation: _____

Address: _____ City/State: _____ Zip: _____

Home Phone: (_____) _____ Cell: (_____) _____ Email: _____

INSURANCE INFORMATION

Complete this section only if you request and authorize us to file medical claims on your behalf.

Insurance Co: Choose Primary ID#: _____ Group#: _____

Subscriber Name: If different from patient Date of Birth: _____ Relationship: Choose One

EMERGENCY CONTACT/NEXT OF KIN

Name: _____ Relationship: Choose One Phone: (_____) _____

PATIENT NOTIFICATION AUTHORIZATION INFORMATION

We recognize the importance of receiving a call or other notification in a timely manner. In order for us to effectively and efficiently deliver information to you when you are unavailable, we request your permission to give information to an authorized designee and / or leave a message, text, or send an email as appropriate. Please check the applicable boxes below and list the name of a person or persons we may speak with if necessary. Such instances would include responses to a waitlist opening, a scheduling or rescheduling concern, or discussion of a therapeutic or administrative nature.

Please list any exceptions or instructions: _____

_____

I authorize Manchester Bedford Myoskeletal to leave any message on my:

☐ Answering machine at home ☐ Cell phone voicemail ☐ Text
☐ Answering machine at work ☐ Email ☐ All

I authorize Manchester Bedford Myoskeletal to leave a message with or speak to those contacts listed below regarding any information that needs to be relayed to me or ☐ No one else but myself ☐ Anyone

Name: _____ Relationship: Choose One Phone: (_____) _____
Name: _____ Relationship: Choose One Phone: (_____) _____

This authorization remains in effect unless otherwise revoked or revised by the patient or guardian.

ACKNOWLEDGEMENTS

All professional services rendered are charged to the patient. Patients are responsible for providing the correct insurance information at the time of service. We will complete the necessary forms to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. I hereby authorize MANCHESTER BEDFORD MYOSKELETAL to furnish information to insurance carriers and I authorize insurance benefits to be made either to me or on my behalf to MANCHESTER BEDFORD MYOSKELETAL.

I acknowledge that the Patient Privacy Notice (HIPAA) and Patients' Rights and Responsibilities have been offered to me and my questions answered.

_____ _____ _____
(Print name) *(Patient/Guarantor Signature)* *(Date)*