

Bruce Rind, M.D.

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Patient Registration

How would you like to be addressed? _____ SSN: _____ DOB: _____ Age: _____

Last Name: _____ First: _____ Middle: _____

Address: _____

Home Phone: _____ Work Phone: _____ Other Phone/E-Mail: _____

If child, parent's name: _____ Parent's address, if different: _____

Spouse's Name: _____ Spouse's work number: _____

Emergency Contact: _____
Name Phone Relationship

Who referred you? _____ Your pharmacy: _____ Pharmacy's Phone: _____

Name of Other Physicians & Health Care Providers

Specialty

Address

Phone Number

Insurance (for Laboratory Purposes)

Primary Insurance: _____

Secondary Insurance: _____

Claims Address: _____

Claims Address: _____

Member ID/Policy: _____

Member ID/Policy: _____

Group/Code: _____

Group/Code: _____

Policyholder's Name: _____

Policyholder's Name: _____

Policyholder's Relation to Patient: _____

Policyholder's Relation to Patient: _____

Financial Policy

Bruce Rind, M.D., Center for Holistic Medicine does **not** participate with any insurance plans, including Medicare and Maryland Medical Assistance (Medicaid). Full payment is expected at time of service by cash, check, money order or credit card. Insurance information will be forwarded to any reference laboratory used for diagnostic studies ordered by Dr. Rind or his associates. The issue of reimbursement is between you and your insurance carrier. Medical documentation needed for your insurance claim will be provided. Any unpaid balances are dues within 30 days of treatment.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named insurance carrier(s). I permit a copy of this authorization to be used in place of the original. This authorization may be revoked in writing either by me or the above-named carrier at any time. I certify that I represent only myself or individual(s) for whom I am guardian and am not here on behalf of a third party. I authorize treatment by any or all providers and professional staff affiliated with Center for Holistic Medicine/Bruce Rind, MD. I understand that Dr. Rind is not my primary care provider.

Patients carrying Medicare or Medicaid may be billed for services.

By signing below I confirm that I have read and understand the financial policy.

Signature of Patient/Legally Responsible Party

Date

Medicare Waiver Signed Medicaid Waiver Signed Acct. #: _____ Staff Member: _____