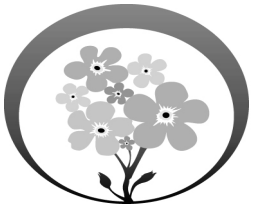

LEGACY HEALTH CLINIC

Nell Klein, FNP-BC • Jessica Pilcher, ANP-BC • Sarah E. Bass, FNP-C

PATIENT REGISTRATION

First Name:_____ Last Name:_____ MI:_____

Date of Birth: _____/_____/_____ Mailing Address:_____

City, State, Zip: _____

Race: _____ (**C**-Caucasian; **B**-Black/African American; **A**-Asian; **G**-Native American; **F**-Asian Pacific American; **P**-Pacific Islander; **D**-Subcontinent Asian American; **I**-American Indian Or Alaskan Native; **E**-Other Race; **M**-More than one race) Ethnicity:_____ (**L**-Latino/Hispanic; **O**-Other)

Preferred Language:_____ Marital Status: Married_____ Single:_____

Employed: Yes____ No____ Employer:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Message Phone:_____

Email Address:_____ Best Way to Contact Me:_____

Emergency Contact Name/Relationship:_____

Emergency Contact Phone:_____ Alternative Phone:_____

Primary Insurance Company:_____

Name of Policy Holder:_____ D.O.B_____

Policy Holder Employer:_____ Phone:_____

Secondary Insurance Company:_____

Name of Policy Holder:_____ D.O.B_____

Policy Holder Employer:_____ Phone:_____

I give consent for telehealth communication whether audio/visual/telephone

Signature: _____ Date: _____

ASSIGNMENT & RELEASE: I hereby authorize my insurance benefits to be paid directly to the provider. I am financially responsible for any balance due. I also authorize the provider or insurance company to release any information required to process claims.

Signature: _____ Date: _____

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RECEPIT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I,_____, have reviewed a copy of Legacy Health Clinic, LLC Notice of Privacy Practices. ("Reviewed" does not indicate I have read, understand or agree with the Notice)

_____

Signature of Patient

_____

Date