Intensive Health
a stepworks company

Patient Registration Form

Name: _____ Today's Date: _____ / _____ / _____

Social Security Number: _____ _____ _____ Date of Birth: _____ / _____ / _____

_____ _____ _____ _____
Street City State Zip Code

Phone: (_____) _____ - _____ Other Phone: (_____) _____ - _____

Email: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other

Gender: ☐ male ☐ female ☐ other

Pronouns: ☐ he/him ☐ she/her ☐ them/they

Marital Status: ☐ single ☐ married ☐ separated ☐ divorced ☐ widowed

Ethnicity: ☐ asian ☐ black ☐ hispanic ☐ white ☐ North American native ☐ other ☐ unknown

Authorization to Release Information

I hereby authorize telephonic/electronic release of medical information to the following person(s):

Full Name: _____ ☐ spouse ☐ parent ☐ child ☐ other

☐ appointment ☐ medical ☐ psych Patient initials: _____

Full Name: _____ ☐ spouse ☐ parent ☐ child ☐ other

☐ appointment ☐ medical ☐ psych Patient initials: _____

Power of Attorney

Do you have a medical power of attorney, living will, or advance directive? ☐ yes ☐ no ☐ I don't know.
If you have one of the above, please bring a copy for your records. If you have questions about this, ask your provider during your visit.

Emergency Contact

Name: _____ Phone: (_____) _____ - _____ Relationship: _____

Primary Insurance

Insurance Name: _____

Member ID: _____

Group Number: _____

Date of Birth: _____ / _____ / _____

Social Security Number: _____ _____ _____

Relationship: ☐ spouse ☐ parent ☐ child ☐ other

Secondary Insurance

Insurance Name: _____

Member ID: _____

Group Number: _____

Date of Birth: _____ / _____ / _____

Social Security Number: _____ _____ _____

Relationship: ☐ spouse ☐ parent ☐ child ☐ other

I authorize the **release of any medical information** necessary to process all insurance claims. Further, I release **payment of medical benefits** to Stepworks Recovery Centers LLC.

I understand that I am fully responsible for **payment at the time of service** and any unpaid account balances including but not limited to, co-payments, co-insurance, and deductibles not paid by my insurance carrier. Accounts not paid in full within 30 days may be subject to a finance charge of up to 18% annually. In addition, should my account become delinquent and referred to a collection agency, I understand that I will be responsible for the balance owed on the account plus all costs incurred in collecting the balance.

_____ _____ _____ / _____ / _____

Patient Signature or Legal Representative Relationship to Patient Date