Life Long Care
of New London, PLLC

Patient Registration Form

PATIENT INFORMATION

Patient Name (Last, First) | Date of Birth | Gender | Social Security Number

Mailing Address | City, State, Zip Code | Marital Status

Email Address | Primary Phone | Secondary Phone

Physical Address | City, State, Zip Code

Emergency Contact

Name | Phone

Guarantor Information (Skip if Patient is Over 18 Years of Age)

Guarantor Name (Last, First) | Guarantor Date of Birth | Guarantor Gender | Guarantor Social Security Number

Mailing Address (If Different From Above) | City, State, Zip Code | Relationship to Patient

Home Phone | Cell Phone | Work Phone (Include Extension)

Primary Insurance Information

Insurance Company | Insurance ID Number | Insurance Group Number

Name of Subscriber (include address if different than patient) | Subscriber D.O.B. | Relationship of patient to insured: Self, spouse, child, other

Secondary Insurance Information

Insurance Company | Insurance ID Number | Insurance Group Number

Name of Subscriber (include address if different than patient) | Subscriber D.O.B. | Relationship of patient to insured: self, spouse, child, other

Life Long Care
of New London, PLLC

Patient Registration Form

TREATMENT AUTHORIZATION AND ADMINISTRATIVE ACKNOWLEDGMENT

AUTHORIZATION FOR TREATMENT: I authorize my provider(s) or his/her designee(s) in charge of my care at Life Long Care to administer any treatment deemed necessary or advisable in the diagnosis and treatment of my conditions. I certify that no guarantee has been made as to the results that may be obtained.
I recognize that I may withdraw this request for treatment, before a procedure, test or medication is administered.

ELECTRONIC MEDICAL RECORD ACKNOWLEDGMENT: Life Long Care primarily uses an electronic medical record system to capture medical information. This system allows my information to be available to my healthcare provider(s) and the staff at Life Long Care. Life Long Care is committed to protecting my privacy in accordance with applicable state and federal laws. A complete description of how my health information may be used and disclosed is contained in the Life Long Care Notice of Privacy Practices, available to me upon request.

HEALTH CARE EDUCATION: I acknowledge that Life Long Care is a teaching facility, and health care workers in training are important members of my health care team. I understand that trainees, under appropriate supervision, may perform or observe some of the health care services that I receive.

RECEIPT OF PATIENT INFORMATION: I acknowledge that I have been offered and/or provided a copy of the Patients' Bill of Rights.

ASSIGNMENT OF BENEFITS AND PAYMENT TERMS: I agree to assign to Life Long Care, all insurance benefits otherwise payable to or on behalf of the undersigned for the services rendered. I agree that I am responsible to pay the balance owed if the insurance or personal information I have given is not true. I understand that I remain liable for all charges not covered by insurance or other benefits. I agree to pay Life Long Care in accordance with its regular rates and terms for all services rendered. All amounts are due immediately, upon receipt of the bill for said services. In the event that the bill is not paid pursuant to these terms and the account is placed with an attorney or agency for collection, I agree to pay actual attorney's fees and cost of collection. I agree to $50 no show fee should I cancel my appointment within 24hours of scheduled appointment time or miss a scheduled appointment. I understand that if I am presenting with a work-related injury, it is my responsibility to provide Life Long Care with accurate information regarding my employer and my workers' compensation insurance. I further understand that I remain liable for all charges not covered by workers' compensation, health insurance or other benefits.

I agree to assign to my treating providers all insurance benefits otherwise payable for the services rendered and agree that I will be responsible for any amount not covered. I grant my permission to Life Long Care to release my medical records for the purpose of claims adjudication.

By signing below I acknowledge that I understand and agree to the terms set forth above.

_____ _____

PRINT NAME **SIGNATURE PATIENT/LEGAL GUARDIAN**

_____ _____

DATE **WITNESS**

276 Newport Road, The Gallery
Suite 107 New London, NH 03257

603-526-4144
603-526-4167

lifelongcare.net
Patient Portal:https://23658.portal.athenahealth.com

Life Long Care
of New London, PLLC

Patient Registration Form

VERBAL AUTHORIZATION
TO DISCUSS MY HEALTH AND MEDICAL INFORMATION

PATIENT NAME:_____DATE OF BIRTH:_____

PARENT OR LEGAL GUARDIAN:_____

o If I am not present, I authorize Life Long Care of New London, PLLC providers and staff to discuss my relevant health information with the family members and/or friends named below.

o I decline to name family members and/or friends who my providers and staff may discuss my health information with at this time. However, I understand that I can always verbally authorize providers and staff to discuss health information with family members and /or friends or I may complete this form at a later date.

For a complete description of how your health information may be used and disclosed, you may request a copy of our Notice of Privacy Practices.

Name:_____Relationship:_____Phone#:_____

Name:_____Relationship:_____Phone#:_____

Name:_____Relationship:_____Phone#:_____

Name:_____Relationship:_____Phone#:_____

The following types of information MAY BE INCLUDED UNLESS indicated by you initialing below:

Drug and/or alcohol treatment: Initials:_____ **Medical treatment for psychiatric conditions: Initials:_____**

Sexually transmitted disease: Initials:_____ **Genetic Testing: Initials:_____**

HIV (AIDS) testing/treatment: Intials:_____

I understand that this authorization is valid and in effect until such time as I withdraw it in writing or in person, or one year following date of signature.

I understand that I can revoke, updated, or change this verbal authorization at any time in writing. The termination to verbally release health and medical information is effective on the date the physician office receives it. It does not apply to any information released prior to the date of receipt of the written termination.

_____ Signature of patient or legal representative/guardian

_____ Authority or relationship of representative (Attach copy of documentation of Authority)

_____ Date