Momentum Medicine Plus, LLC-*Weightloss* *Rev 1/14*

PATIENT REGISTRATION FORM

Name:_____ Date:____/____/2014
Address:_____
City:_____ State:_____ Zip code:_____
Phone #: ( )_____ Email Address:_____ SSN# (Social):_____
Age:_____ **Sex**: □ Male □ Female **Marital Status**: □ Married □Single □Divorced □Separated □ Widowed
Birthdate:___/____/____

Occupation:_____ Employer:_____ Work #:_____
Work Address:_____ City:_____ State:_____ Zip Code:_____
Employment Status: □ Full Time □ Part Time □Unemployed □Disabled □ Student □Other:_____

Primary Care Physician/Treating Physician:_____ Phone:_____
Emergency Contact: Full Name:_____ Relationship:_____ Phone:_____

INSURANCE INFORMATION

Thank you for selecting Momentum Medicine Plus-*Weightloss*. Unfortunately, most insurance companies do not pay for weight loss services. If you are seeking insurance reimbursement for your payment we will provide you an itemized statement with the applicable codes for insurance reimbursement of your medical weight loss treatment. We do not process insurance claims in our office. Thus, payment for all services are required at the time of your visit. For your convenience, we accept Cash, Visa, or MasterCard.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

We have a 24-hour cancellation policy for any no-show appointments or late cancellations. You will be charged $30.00 if 24 hour notice is not given. This fee will need to be paid before any further appointments can be made.

PATIENT ACKNOWLEDGEMENT AND UNDERSTANDING OF ABOVE

I consent to evaluation and the release of information as stated above.
Signature of examinee :_____ Printed Name:_____ Date:___/___/2014
Witness Signature:_____ Printed Name:_____ Date:___/___/2014