COACHING CLIENT REGISTRATION – GALEN MEDICAL GROUP, PC

CLIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____

SOCIAL SECURITY # (last 4): _____ REFERRING PHYSICIAN: _____

EMPLOYER: _____ OCCUPATION: _____

COMMUNICATION PREFERENCES

MAY WE LEAVE MESSAGES BY:	**EMAIL**	**TEXT CELL**	**HOME PHONE**	**WORK PHONE**	**CELL PHONE**
For Wellness Newsletters & Events	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
For Appointment Reminders	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**

PAYMENT IS REQUIRED PRIOR TO YOUR APPOINTMENT

I understand this is a self-pay service and not reimbursable by insurance. Payment is required prior to my appointment. Payments are to be made online via the MYGalen Patient Portal or in person at my appointment.

_____ _____

Signature of Patient ***Date***

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____, grant permission for the person(s) listed below to have access to any and all of my medical information that pertains to my care from the healthcare professional of this group. This includes, but is not limited to, appointment times, appointment notes, my health coaching plan for health and wellness, etc.

Signature: _____

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

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

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

I AGREE TO NOTIFY GALEN MEDICAL GROUP, IN WRITING, IF THERE ARE ANY CHANGES IN PERSON(S) AUTHORIZED

ADVANCED DIRECTIVES:

It is the right of every adult citizen in Tennessee and Georgia (18 years and over) to sign a Living Will, as well as a Durable Power of Attorney for Health Care that empowers an Individual of your choosing to see that your wishes are carried out. It is important to decide whether or not you wish to sign a Living Will now when you are fully competent to make your own decision. The choices you make in your Living Will will be binding on doctors, hospitals, and other healthcare providers in the event you become incapable of telling them your wishes. If you have signed either document, please make sure your provider has a copy for your file.

AUTHORIZATION:

I authorize Galen Medical Group, PC to release to my insurance company, managed care organization, state agency(ies), federal agency(ies), Health Care Financing Administration, third Party Administrators, and/or Workers' Compensation or its agents any information needed to process my claim and/or determine benefits payable for related services. I also authorize Galen Medical Group, PC to utilize a fax machine to transmit any or all of the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of my medical records. I grant permission to Galen Medical Group, PC to release all or part of my medical record to any consulting entity that may be involved in my medical care. This includes, but is not limited to, testing facilities, consulting physicians, and outpatient facilities.

I request that payment of Medicare, MediGap, Traveler's Railroad Retirement, Managed Care Organization, Third Party Administrators, Commercial, Workers' Compensation, Liability, and/or any other insurance benefits be made on my behalf to Galen Medical Group for services furnished to me or on my behalf by that provider.

I understand that I am financially responsible for deductible amounts, co-payments, co-insurance amounts, non-covered charges and any and all balances not covered under a contractual write-off agreement between Galen Medical Group and my third-party payer. My carrier's failure to pay does not release me from this responsibility. I also agree that should this account be turned to collection, I will be responsible for all costs associated with debt collection, including attorney fees and court costs.

_____ _____ _____

Signature of Patient ***Date*** ***Signature of Responsible Party/Insured***

PLEASE COMPLETE ADDITIONAL INFORMATION ON THE BACK OF THIS SHEET