BACK TO HEALTH OF BRANFORD, LLC.
203-481-2225 / 400 West Main St. Branford

REGISTRATION

Date________________________

Patient____
Last Name First Name Initial

Address____ City_______________________State__________Zip______________________

Home Phone (_____)_______________________ Cell Phone (_____)________________________

Sex ☐ M ☐ F Age____________ Birthdate___________________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #____________________________________ Email Address: _____________________________________

Insured's Name____
Last Name First Name Initial

Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other Condition Related to ☐ Illness ☐ Employment ☐ Auto ☐ Other

EMPLOYER	Company Name____________________________________Occupation_______________________________ Address____Phone__________________________ City________________________________State_____________Zip_________________________________
SPOUSE	Name____ Last Name First Name Initial Birthdate__________________________Social Security #_______________________________________
PATIENT INSURANCE INFORMATION	Please √ any and all insurance coverage you or your spouse has applicable in this case. □ MEDICARE □ BLUE SHIELD □ AUTO ACCIDENT/Date_______________ □ MEDICAID □ MAJOR MEDICAL □ UNION PLAN □ BLUE CROSS □ WORKER'S COMPENSATION □ OTHER Insurance Company Name______________________________________ Adjuster______________ Address/Phone____ Claim # ______________ Policy #____ Effective Date______________
SPOUSE CO-INSURANCE INFORMATION	MAJOR MEDICAL ONLY Insurance Company Name____ Address/Phone____ Policy #____ Effective Date_______________
MEDICAL AND LEGAL INFORMATION	Referred by____ Attorney____________________________ Present Complaint___________________________________ Address____________________________ Known Medical Problems___________________________ _______________________________ ____ Phone____________________________ Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician__________________________ Person to contact in emergency (Name and Phone #) ____
PATIENT AGREEMENT	ASSIGNMENT AND RELEASE I, the undersigned, have insurance coverage with ____ Name of Insurance Company And assign directly to Dr.____________________________________ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. ____ __________________________ Signature of Insured/Guardian Date

OFFICIAL FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your Insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If You Do Not Have Insurance:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.
2. **If You Have Insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-Insurance balance may not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

   You are considered a cash patient until you bring in your completed Insurance forms, and we qualify and accept your Insurance coverage. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.

   Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not app0ly to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

   If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your Insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your cr4edit card to collect full payment.

   When your schedule of visits is once per month or longer, you will not be eligible for Insurance assignment. Charges for services rendered will be due as they are rendered. We will continue to provide you with an insurance claim form.

   If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Patient's Printed Name: ____________________________

Signature: ____ Date: _________________

Finance Counselor: _______________________________ Date: _________________

Front Desk: ______________________________________ Date: _________________

For your convenience you may retain your credit card number on file with us.

Card # ____ Expiration Date: _________

Name as appears on card ____________________________

Medical History

Present Complaint: Why did you come to see the Doctor today?

____

____

____

Medical History: Please check any of the following that apply to your medical history.

__ Allergies
__ Anemia
__ Arthritis
__ Asthma
__ Backaches
__ Bowel Problems
__ Breast Lump
__ Cancer
__ Chest pain/pressure
__ C?
__ Convulsion
__ Diabetes
__ Digestive problems
__ Dizziness
__ Epilepsy
__ Hardening of arteries
__ Urinary Bladder disease
__ Skin disease/rash
__ Head/spinal injury
__ Heart trouble
__ Hepatitis
__ High blood pressure
__ Impaired vision or hearing
__Lung disease/cough blood
__ Nervousness/Depression
__ Permanent injury/illness
__ Polio
__ Prostate condition
__ Rheumatic fever
__ Seizures/Fits/Fainting
__ Shortness of breath
__ Sinus trouble
__ Stroke
__ Thyroid condition
__ Tuberculosis
__ Venereal Disease
__ Vascular Disease
__ Ulcers of the stomach
__ Gout
__ Extended Confinement from injury/illness
__ Fracture/breaks/sprain/dislocation
__ Have you ever used marijuana, cocaine, LSD or other drugs?

Explanation: Please provide a brief explanation of the conditions you have checked.

____

____

Surgeries: List any surgeries and the date(s) of surgery.

____

____

Allergies: List any allergies you have. **IF NONE, WRITE NKA (NO KNOWN ALLERGIES)**

____

____

Medications: List all medications you are taking and the dosages.

____

____

Family History: List parent or grandparent(s) medical problems and/or cause of death and the age effected.

____

____

Social History:

Cigarette Smoker __ Yes __ No Packs per day ________ How long __________________

Alcohol: __ Yes __ No Daily consumption ____________ How long _________

Occupational History: Briefly describe your occupation and/or any hazardous exposures

____

____

Patient Signature: ____ Date: _________

Doctor's Signature: ____ Date: _________

Patient's Last Name: _________________________First Name _________________________ DOB: _________

BACK TO HEALTH OF BRANFORD, LLC.
400 WEST MAIN STREET
BRANFORD, CT 06405

PATIENT CONSENT AUTHORIZATION

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges that the insurance carrier declines to pay.

RELEASE OPF INFORMATION: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or to a family member or employer of the patient for all part or part of the physician(s) charges, including but not limited to, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

H.M.O. DISCLAIMER: I CERTIFY THAT I AM NOT PRESENTLY ENROLLED IN ANY Health Maintenance Organization (HMO). Subsequent rejection of a claim as a result of this admission, sue to current enrollment in an H.M.O. plan will constitute responsibility for payment of claim on my part.

MEDICARE AND MEDICAID PATIENT CERTIFICATION – PATIENTS CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act, is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health Insurance deductibles and coinsurance.

Verification of non-pregnancy

Date ____________File# _________________

X ______________________________
Print Patient's Name

Date of L.M.P. __________________________

X ______________________________
Patient's Signature

By my signature on this form I do hereby State that to the best of my knowledge, I am Not pregnant, nor is pregnancy suspected or confirmed at this particular time.

X ______________________________
Other than patient, Print name & relationship

X ______________________________
Witness

BACK TO HEALTH OF BRANFORD, LLC.

Jorden Goetz, M.D.
Jennifer Botwick, N.D.
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ACKNOWLEDGMENT OF RECEIPT AND/OR OPTION OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I:

____ Was provided a copy of the Notice of Privacy Practices,

____ Was provided a copy of the Notice of Privacy Practices and declined a copy,

And that I have read them or declined the opportunity to read them and understand the notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

____
PATIENT NAME (PLEASE PRINT)

______________________________ ______________
SIGNATURE DATE

______________________________ ______________
PARENT, GUARDIAN OR PATIENTS' DATE
LEGAL REPRESENTATIVE (PLEASE PRINT)

______________________________ ______________
SIGNATURE DATE

______________________________ ______________
WITNESS DATE