GOODALL-WITCHER Healthcare

Goodall-Witcher Hospital
Goodall-Witcher Clinic in Clifton
Goodall-Witcher Clinic in Whitney
Goodall-Witcher Home Health Agency
Goodall-Witcher Nursing Facility
Goodall-Witcher Fitness & Wellness Center

PATIENT REGISTRATION FORM

Patient Information:

Last Name	First Name	Middle Initial
Mailing Address	City/State/Zip Code	Social Security #
Phone Number	Date of Birth	☐ Male ☐ Female

Race (check one):			Ethnicity (check one):	
☐ Black or African American	☐ American Indian/Alaska Native	☐ Asian	☐ White, Non-Hispanic	☐ Hispanic
☐ Refuse to answer	☐ Native Hawaiian or Pacific Islander	☐ White	☐ Refuse to answer	☐ Unknown
	☐ Unknown			

Email Address	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced	Spouse name & DOB
Emergency Contact & Phone #	Email address	

Employer Information:

Name	Work Number	Occupation
Address	City/State	Zip Code

Responsible Party (if patient is a Minor, relationship to patient)

Name	Address	Social Security #
Relationship to Patient	Date of Birth	Phone Number

I authorize payment of medical benefits to Goodall-Witcher Healthcare. This authorization shall remain valid until revoked, in writing, by patient or guarantor. Please note that Goodall-Witcher Healthcare reserves the right to not accept assignment of benefits when such assignment conflicts with benefit contracts or policies. I request that payment of authorized Medicare benefits be made on my behalf for any services furnished to me by or in Goodall-Witcher Medical Clinics, including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or insurance company any information needed to determine these benefits for related services.

Some health insurance carriers require the patient to pay a co-pay for services rendered. We will collect your co-pay at the time of service for every office visit.

If you do not have insurance, a self-pay fee will be required at time of office visit.

I understand that it is my responsibility to provide Goodall-Witcher Healthcare with current, accurate billing information and a current health insurance card at each office visit to ensure accurate billing for services rendered.

My signature below confirms that I have read these billing policies and understand my financial obligations pertaining to the medical providers at Goodall-Witcher Healthcare Clinics.

I ☐ accept or ☐ decline (please choose one), services from a Family Nurse Practitioner or Physicians' Assistant.

Signature of Patient or Authorized Representative	Relationship to Patient	Date