REGISTRATION FORM

Patient Name: _____ Date of Birth: __/___/_____ Today's Date: ___/ ___ / 20___

Your **Marital Status**: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐Widowed

Home Phone Number: _____ **Cell Phone Number:** _____

Your Email Address: _____

How would you like to be reminded of your appointment? (Note: We charge for missed appointments, more is better)

☐ **Phone Call** to your ☐ **Home Phone or** ☐ **Cell Phone:** (Please choose ONLY one of these two)

☐ **Text** reminder to your **Cell Phone**

☐ **E-Mail** reminder

Your **Primary Care Physician**: _____ Location: _____

Your Employer: _____ Your Spouse's Name: _____

Your Spouse's Cell #:(____) _____ Your Spouse's Employer: _____

IF YOUR PROBLEM IS DUE TO AN INJURY, PLEASE BE SURE TO COMPLETE THIS SECTION.

Is your problem due to an **injury**? _____? If yes, was it due to: ___ Auto Accident ___ Work ___ Slip & Fall

Insurance Company: _____ Phone # :(_____) _____

Adjuster / Claim Representative's Name: Date of Injury:

IN CASE OF EMERGENCY, CONTACT

Name (Must be someone **not living with patient**) _____ Relationship: _____

Telephone: ( )

Your **PREFERRED PHARMACY** is: _____ Location: _____

Cross Streets:_____ Phone Number: _____

LATE CANCELLATION / NO SHOW POLICY AGREEMENT:

I acknowledge that a **Late Cancellation** is cancelling an appointment with less than 24 hour / one business day notice and a **No Show** is when I do not show for my appointment. I further acknowledge that David S Weingarden MD & Assoc PC charges fees for missed (Late Cancellation/No Show) visits. There are larger charges for second or multiple missed visits or visits that are booked longer slots in the Doctor's schedule (such as New Patient visits). The Late Cancellation/No Show charges are available online at www.DSWMD.com and are attached and available upon request. Charges will be updated from time to time. The fee is my responsibility and not the insurance company and is due upon receiving the bill. Reminders are provided as a courtesy, and if for some reason I do not receive any reminder, the fee still remains in effect. I acknowledge all of the above and my responsibility to pay any charges.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I authorize David S Weingarden MD & Assoc. PC to furnish information to insurance carriers for the purpose reviewing my medical coverage and/or for the processing of claims for services rendered to me or my dependent. I assign to David S Weingarden MD & Assoc. PC all payments for medically related services rendered by them, to myself or my dependent. This authorization and assignment will remain in effect until revoked by me in writing. I understand and agree that I am responsible for any amount not covered by my insurance. I also agree to reimburse David S Weingarden MD & Assoc. PC the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorneys' fees, incurred in such collection efforts. I will also be responsible for any charges for returned checks due to insufficient funds.

NOTICE OF PRIVACY AND TEXTING PRACTICES: I acknowledge that I have received a copy of the Notice of Privacy Practices. I am aware that the Notice of Privacy Practices is available on the Practice web page at www.dswmd.com. I also agree to allow the Practice to send me automated text messages, emails and or phone calls to the numbers or addresses I have provided, for appointment reminders and/or communications from DSW MD & Assoc PC.

My signature below attests to my authorization & acknowledgement of all the sections above
(Late Cancellation / No Show Policy, Insurance Authorization & Assignment, Notice of Privacy and Texting Practices)

Name & Signature: _____ **Date:** _____