Anna M. Knight, MD
Oncologic Breast Surgeon

Registration Information

PATIENT INFORMATION (Please Print Clearly)

FIRST NAME: ____________________________MI: __________LAST NAME: ___________________________________

ADDRESS: ____ CITY: ________________STATE: ______ ZIP CODE: ______

PRIMARY PHONE: __________________ SECONDARY PHONE: ________________ DATE OF BIRTH: _________________

SOCIAL SECURITY #: ____________________ SEX: M / F EMAIL ADDRESS: _______________________________

EMPLOYER NAME: ____EMPLOYER PHONE #: __________________

EMPLOYER ADDRESS: ____

IN CASE OF EMERGENCY, CONTACT: _______________________________ RELATIONSHIP: _______________________

HOME PHONE: ____________________________ CELL PHONE: ____

INSURANCE INFORMATION: DO YOU HAVE HEALTH INSURANCE? YES / NO

PRIMARY INSURANCE CARRIER INSURANCE COMPANY: ____

POLICY #: ____ GROUP #: _______________________________________

NAME & DATE OF BIRTH OF INSURED: ____

SECONDARY INSURANCE CARRIER INSURANCE COMPANY: ____

POLICY #: ____ GROUP #: ____

NAME & DATE OF BIRTH OF INSURED: ____

I AUTHORIZE THE STAFF/PHYSICIAN OF COMPREHENSIVE BREAST HEALTH, LLC TO DISCUSS ANY MEDICAL OR FINANCIAL INFORMATION WITH THE FOLLOWING INDIVIDUAL:

NAME: ____ PHONE: ____

TREATMENT AUTHORIZATION

I HEREBY AUTHORIZE DR. ANNA M. KNIGHT TO UNDERTAKE EVALUATION AND TREATMENTS OF THE VARIOUS CONDITIONS FOR WHICH I PRESENT MYSELF.

SIGNATURE OF PATIENT ____DATE: ____________________

(PATIENT or LEGAL guardian's signature if patient is a minor)

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PAYMENT AUTHORIZATION

I hereby authorize Comprehensive Breast Health, LLC to furnish medical information concerning my visits to my insurance company. I direct the insurer to pay, directly to the physician, all benefits due her as a result of these claims. I am aware that I am personally responsible for all charges. If such charges are left unpaid after multiple billings have been made, and if at that time, the physician should then determine that it is appropriate the account be forwarded to a collection agency or an attorney, or for any court costs and reasonable attorney fee involved in collection of any amounts due from me.

SIGNATURE OF PATIENT: ____DATE: ____________________

(PATIENT or LEGAL guardian's signature if patient is a minor)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, I acknowledge that I have received a copy of the Comprehensive Breast Health, LLC's Notice of Privacy Practices.

__________________________ ________________________________ _____________________________

Date Chart Number Date of Birth

________________________________ _____________________________

Patient Name Signature of Patient

Name of Patient Representative (if applicable) ________________________________

If signing as a personal Representative, describe authority to act for patient and submit documentation showing authority: ____

_______________________________ Witness (signature of office staff)

For Staff Only
Reason Privacy Notice Acknowledgement Not Obtained:
o Patient was provided notice but refused to sign acknowledgement
o Patient not present (obtain when present)
o Patient indicated they had already received and/or signed acknowledgement
o Emergency situation (patient unable to sign acknowledgement due to emergency)
  o Notice was provided to patient as soon as reasonably possible after emergency situation, OR
  o Notice was provided to patient as soon as reasonably possible after emergency, but the patient refused to sign acknowledgement