John T. Hart, M.D.
FUNCTIONAL MEDICINE FOR FAMILIES & GYNECOLOGY
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PATIENT REGISTRATION

Last Name_____ First Name: _____ Middle Initial: ___

Address: _____ Marital Status: M D S W

City: _____ State: _____ Zip: _____-_____

Date of Birth:_____ Age: _____

If patient is a child, parent's name: _____

Home phone: _____ Work phone: _____

Cell phone:_____ Email :_____

Work Name and Address: _____

How did you learn about Dr. Hart? _____

Primary Physician's name: _____ Phone Number: _____

Primary Physician's Address: _____

Purpose for visit: _____

Insurance Company Name: _____
Name of Policy Holder: _____
I.D. Number: _____ Group Number: _____
Customer Service/Pre-certification Phone Number: _____

John T Hart, MD, LLC, Functional Medicine for Families, does **not** participate with any insurance plans including Medicare and Medicaid. Full payment is expected at time of service by cash, check or credit card. Insurance information will be forwarded to any reference laboratory used for diagnostic studies ordered by Dr. Hart or his associates. The issue of reimbursement is between you and your insurance company. Medical documentation needed for your insurance claim will be provided. Any unpaid balances are due within thirty days of treatment. Payment is due at time of service.

I certify that the information I have provided regarding my insurance coverage is correct and further authorize the release of any necessary information for this or any related claim, to the above named insurance carrier. I authorize the treatment by any or all providers or professional staff affiliated with Functional Medicine for Families/Dr. Hart. I understand that Dr. Hart is not my primary provider.

CANCELLATION POLICY: Cancellations must be made at least 24 hours in advance. Failure to comply will result in a $100.00 cancellation fee.

By signing below I acknowledge that I have read, understand, and will comply with the financial policy.

_____ _____
Signature of Patient/or Responsible Party Date