The Healing Touch Medical Care S.C
Richa Srivastava MD
802 East Woodfield Road, Ste. 300
Schaumburg, IL 60173
Phone: (847) 773-5080
Fax: (847) 348-3848

PATIENT REGISTRATION

Patient information :

Last name _____ First Name _____ MI_____
Street Address _____Apt Number _____
City _____ State _____ Zip code _____
Date of birth _____ Sex: Male / Female
Home phone _____ Cell phone _____
Email Address: _____
Employer Name _____ Work number _____
Work Address _____
Preferred number to contact: home / cell / work

Preferred pharmacy _____pharmacy number_____
pharmacy address _____

Emergency Contact Name _____Relationship _____
Emergency Contact's Number _____

Insurance Information:

Primary Insurance: Name _____
HMO OR PPO HMO Group name _____
ID Number _____ Group Number _____
Address _____
Phone number _____
Subscriber (if not patient) _____Relationship to patient _____

Secondary Insurance: Name _____
HMO OR PPO HMO Group name _____
ID Number _____ Group Number _____
Address _____
Phone number _____
Subscriber (if not self) _____Relationship to patient _____

Responsible Party(if not patient)_____
Relationship to Patient _____Date of birth _____
Address _____
Phone Number _____Work Number _____

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Authorization and Release of Information

Please initial each line and sign at the bottom of the page.

_____ I give my consent to Dr. Srivastava and her agents to use or disclose, for the purpose of carrying out treatment, payment, or healthcare operations, any and/or all protected health information contained in my patient record.

_____ I request that payment of authorized insurance, Medicare, and Medicaid benefits be made for any services furnished to me by the above named physician. I am aware that I responsible for any and all balances remaining there after.

_____ I have received and reviewed the OFFICE AND FINANCIAL POLICIES and agree to the policies out lined in the document. The Healing Touch Medical Care S.C. reserves the right to revise its Office and Financial Policies at any time, at which time a revised copy will be available for me to obtain.

_____ I have received and reviewed the NOTICE OF PRIVACY PRACTICES and agree to the policies out lined in the document. The Healing Touch Medical Care S.C. reserves the right to revise its Notice of Privacy Practices at any time, at which time a revised copy will be available for me to obtain.

Please mark your choice to the following statements:

_____ I give my consent for Dr. Srivastava and her agents to leave telephone messages at my :
_____home
_____ cell
_____work

_____ I **do not** give my consent for Dr. Srivastava and her agents to leave telephone messages.

_____ I **do not** consent to the discussion of health/ medical issues with anyone other than myself.

_____ I give Dr. Srivastava and her agents my consent to discuss medical/ health issues with the following individuals:

_____ relationship _____ phone_____
_____ relationship _____ phone _____
_____ relationship _____ phone _____
_____ relationship _____ phone _____

Printed Patient name _____ **Patient Signature** _____
Date: _____