15215 Shady Grove Rd. # 100
Rockville, MD 20850
(301) 519-0902
Fax (301) 519-0905

EMPLOYER PAID SERVICE PATIENT REGISTRATION FORM

PATIENT REGISTRATION INFORMATION

Patient Name:_____ **Date of Birth:** _____
Last First MI

Home Phone:_____ **Cell Phone:**_____ **Work Phone:** _____

EMPLOYER

Employer Name:_____ **Employer Phone #:**_____

Employer Address:_____

Contact Person:_____

EMERGENCY CONTACT

Name:_____ **Relationship with patient:**_____
Last First MI

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

HUMAN RESOURCES CONTACT/SUPERVISOR SENDING EMPLOYEE FOR SERVICE

HR/supervisor Name:_____

Email address:_____

Phone number: _____ **Fax number:** _____

Service needed:_____

Above information is true to the best of my knowledge. I understand that because this service(s) is provided to me by Physicians Now that I am ultimately financially responsible for the payment if my employer for whatever reason does not pay for it. I understand that my records and medical information may be shared with my employer when that employer has requested the services provided. I consent for treatment by the patient care staff at Physicians Now and acknowledge that no guarantee can be made concerning the results of that treatment. I acknowledge that the Notice of Privacy Rights (HIPPA) has been made available to me.

Patient/Guardian Signature:_____ **Date:** _____