PATIENT REGISTRATION

Please fill out completely

Creating Vitality
Michael T. Byrne, ND, LMHC
2008 NE 65th St, Seattle, WA 98115
Tel: (206) 459-1996
Fax: (206) 729-0199

First Name: _____ MI: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of birth: _____ Email: _____

Employer: _____ Mobile Phone #: ( ) MSG Okay: ( ) YES ( ) NO

Gender Identity: ( ) Male ( ) Female Home Phone #: ( ) MSG Okay: ( ) YES ( ) NO

( ) Non-binary Work Phone #: ( ) MSG Okay: ( ) YES ( ) NO

Employment: ( )Employed ( )F/T Student ( )P/T Student ( )Retired ( )Other

Marital Status: ( )Single ( )Married ( )Divorced ( )Widowed ( )Dependent ( )Partnered ( )Other

Responsible Party: _____ Phone:_____

Address: _____ City:_____ State:_____ ZIP: _____

Emergency Contact: _____ Phone: ( )

Referred By:_____

PRIMARY INSURANCE

Insurance Company Name: _____

Subscriber's Name: _____ Date of Birth: _____

Relationship to you: ( ) Self ( ) Spouse ( ) Dependent ( )Other

I.D. # as shown on card: _____ Group #: _____

SECONDARY INSURANCE

Insurance Company Name: _____

Subscriber's Name: _____ Date of Birth: _____

Relationship to you: ( ) Self ( ) Spouse ( ) Dependent ( )Other

I.D. # as shown on card: _____ Group #: _____

I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service I may be billed and held responsible for all charges. I understand that if I fail to cancel an appointment at least 24 business hours in advance, I may be assessed a fee. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

Signature: _____ **Date: _____**