










Covenant Health Centers

 Alabama Pain Center	 Alabama Therapeutic Center	 Alabama Recovery Center	 Alabama Fibromyalgia Center	 Alabama Family Practice Center	 Alabama Sleep Disorders Center	 Cullman
600 Whitesport Drive, Huntsville, AL 35801 • 256-882-2003 (Pain, Therapy, Recovery) • 256-256-882-1155 (Fibromyalgia)			185 Chateau Drive, Suite 302, Huntsville AL 35801 • 256-705-4402 (Family) • 256-428-8232 (Sleep)		1701 Main Ave. SW, Cullman AL 35055 • 256-775-7246	

PATIENT REGISTRATION FORM

PLEASE PRINT

Name: _____ Date of Birth: _____ Age: ____ SSN: _____

Sex: Male Female Marital Status: Single Married Legally Separated Divorced Widowed

Race/Ethnicity: American Indian/Alaska Native Asian Black/African American Hispanic White
Native Hawaiian/Pacific Islander Other Race Primary Language: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

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

Email Address: _____ May we mail important information to this address, including
patient health information? Yes No

Employer: _____ Occupation: _____

Employer's Address: _____

If self-employed, name of business: _____ Address: _____

Name of Spouse: _____ Social Security #: _____ Date of Birth: _____

Spouse's Employer: _____ Occupation: _____

IF RESPONSIBLE PARTY IS OTHER THAN PATIENT, PLEASE COMPLETE:

Responsible Party's Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

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

In Case of Emergency, Notify: _____ Relationship: _____ Phone: _____

Primary Insurance Company _____ **ID #** _____ **Group #** _____

Subscriber's Name _____ Relationship to Patient _____

Secondary Insurance Company _____ **ID #** _____ **Group #** _____

Subscriber's Name _____ Relationship to Patient _____

GENERAL CONSENT FOR CARE: *I acknowledge that I choose to enter into care at the Alabama Pain Center, LLC, d/b/a Covenant Health Centers, and hereby give my consent for such care. I understand that I may be asked for additional consent for specific procedures and/or tests.*

AUTHORIZATION & ASSIGNMENT: Please Read and Sign the Following Statement:

I directly assign all health insurance benefits to the Alabama Pain Center, LLC d/b/a Covenant Health Centers and understand that I am financially responsible for all charges not covered by my insurance. I hereby authorize the Alabama Pain Center, LLC d/b/a Covenant Health Centers, to release all information necessary to secure payment of benefits. I further agree that photocopy of this agreement shall be as valid as the original.

I understand that payment is required at the time of service unless prior arrangements have been made. In the event of non-payment, either by my insurance or myself, I agree to pay all costs of collection, including a reasonable attorney's fee in the event it is necessary to employ an attorney to enforce any provision of this contract. I/We further agree to waive my/our rights of exemption under the laws of the State of Alabama or any other state.

Signature: _____

Date: _____