Client Registration Form

Name:_____ Date:_____

Address:_____ City/State/Zip:_____

Cell Phone:_____ Home Phone: _____

Email:_____ DOB:_____

Social Security #_____ Are you pregnant? ◯ Yes ◯ No

Next of Kin: _____ Relationship:_____ Phone:_____

Preferred contact: ◯ Email ◯ Cell Phone (◯ Call ◯ Text) ◯ Home Phone

Primary Insurance:_____ Effective Date:_____
Plan:_____ ID #:_____ Group #:_____
Subscriber:_____ Relationship:_____
Subscriber's SSN:_____ Subscriber's DOB:_____
Do you have secondary insurance? ◯ Yes ◯ No

I certify that the information on this form is correct to the best of my knowledge. I hereby authorize my insurance company to make payment directly to my provider should claims be filed. I authorize my provider to release any information necessary to process my benefits or insurance claims. I understand the final outcome for my insurance benefits level and the processing of my claims is under the discretion of the insurance company. I will not hold Larsen Billing Service (LBS) or my provider responsible for the information reported on this verification or the manner in which my claims process.

In some cases, insurance claims may be denied and require an appeal process. In this circumstance, I authorize LBS to pursue appeals on my behalf. I understand this will be at the discretion of LBS and that there is no additional charge for this service. I allow LBS to contact me via email or phone if necessary if appeals are pursued.

Signature:_____ Date:_____