RCSC FORM#2

SWVTC-REGIONAL COMMUNITY SUPPORT CENTER
160 Training Center Road
Hillsville, VA 24343

PATIENT REGISTRATION/CONSENT

NAME: _____ SSN: _____
Last First Middle

ADDRESS: _____
Street City Zip

HOME TEL #: _____ CASE MANAGER: _____
Name Tel #

DOB: _____ AGE: _____ SEX: Male Female

PRIMARY CARE PHYSICIAN: _____

_____
Name Address Phone #

PRIMARY INSURANCE	SECONDARY INSURANCE	TERTIARY INSURANCE
Ins. Co. Name _____	Ins. Co. Name _____	Ins. Co. Name _____
Address _____	Address _____	Address _____
_____	_____	_____
ID# _____	ID# _____	ID# _____
Group# _____	Group# _____	Group# _____
Subscribers	Subscribers	Subscribers
Name _____	Name _____	Name _____
Relationship _____	Relationship _____	Relationship _____

PATIENT AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS

AUTHORIZATION FOR TREATMENT: I consent to examination, treatment and procedures which may be performed during office or home visits including emergency treatment considered necessary by the physician and/or his/her designated providers. I consent to treatment or procedures, which may be performed by other clinical staff.

Signed: _____ Date: _____
Patient/guardian/AR

RELEASE AND ASSIGNMENT: I hereby authorize the Southwestern Virginia Training Center to release to my insurance carriers information concerning my illness and treatment and hereby assign to the above all payments for covered services rendered to myself or my surrogatee. I permit a copy of this authorization to be used in place of the original. Either the insurance carrier or I may revoke this authorization at any time, in writing.

Signed: _____ Date: _____
Patient/guardian/AR