

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 #
<b>PRIMARY INSURANCE</b>	<b>SECONDARY INSURANCE</b>		<b>TERTIARY INSURANCE</b>
Ins. Co. Name _____ Address _____ _____	Ins. Co. Name _____ Address _____ _____		Ins. Co. Name _____ Address _____ _____
ID# _____	ID# _____		ID# _____
Group# _____	Group# _____		Group# _____
Subscribers Name _____	Subscribers Name _____		Subscribers 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 surrogate. 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