

**Full Circle Family Care
JOSEPHINE KUHL, MD
Client Registration**

Client's Name _____ Maiden Name: _____
(Last) (First) (M.I.)

Address _____
(Number and Street) (City) (State) (Zip)

Home Phone Number _____ Work Phone Number _____

Mobile Phone Number _____ Email _____

Date of Birth _____ Social Security # _____

Marital Status: M S W D Separated Spouse's Name _____

Pharmacy _____ Phone Number _____

IF CLIENT IS UNDER 18:

Name of Parent or Guardian _____

Address of Parent or Guardian _____
(Number and Street) (City) (State) (Zip)

Home Phone Number _____ Work Phone Number _____

Mobile Phone Number _____ Email _____

INSURANCE INFORMATION-PLEASE NOTE THAT DR. KUHL IS NOT A PARTICIPATING PROVIDER

Primary Insurance _____ Secondary Insurance _____

Member # _____ Member # _____

Group # _____ Group # _____

Name of Insured _____ Name of Insured _____

Insured SS# _____ Insured SS# _____

Insured DOB _____ Insured DOB _____

Co-pay Amount _____ Co-pay Amount _____

How were you referred to Full Circle Family Care?

I hereby authorize Dr. Josephine Kuhl to release any medical information necessary to process claims and to apply for benefits on my behalf for covered services furnished to me by Dr. Josephine Kuhl. I certify that the insurance information supplied is correct and understand I will be responsible for any services not covered by insurance. I also understand that any co-pay I have with my insurance plan is *due at the time of service*.

Signature _____ Date _____

CANCELLATION POLICY:

I understand that if I do not cancel an appointment at least 72 hours in advance I will be charged for the appointment.

Signature _____ Date _____