

**ALALA,LLC**  
**REGISTRATION FORM**

(Please Print)

Today's date: \_\_\_\_\_

CMF: \_\_\_\_\_

I AM HERE TODAY FOR:     BREAST PROSTHETIC & BRA     WIG     COMPRESSION     OTHER: \_\_\_\_\_

**CUSTOMER INFORMATION**

Mr.     Miss  
 Mrs.     Ms    Name: \_\_\_\_\_ Marital status (circle one)    Single / Mar / Div / Sep / Wid

Street address: \_\_\_\_\_

Apt. Number: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Home phone number \_\_\_\_\_ Cell # \_\_\_\_\_ Email: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:     M     F    Current bra size \_\_\_\_\_

Insureds Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer phone: \_\_\_\_\_

How did you find us? (please check one box and fill in name):     Dr. \_\_\_\_\_     Friend \_\_\_\_\_

Family \_\_\_\_\_     Yellow Pages    Other \_\_\_\_\_

Physician Name: \_\_\_\_\_ UPIN: \_\_\_\_\_

Do you have your Prescription?     Yes     No    Do you have a Letter of Medical Necessity?     Yes     No

**INSURANCE INFORMATION**

(Please present your insurance card and driver's license with this completed form.)

Are you covered by insurance?     Yes     No

Person responsible for bill: \_\_\_\_\_ Best phone no.: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Birth date: \_\_\_\_\_

Please indicate primary insurance     Aetna     Blue Cross/Shield     Carolina Plan     Cigna     Medicare     Medicaid

Mega Health     Tricare    Other: \_\_\_\_\_

Subscriber's name: \_\_\_\_\_ Policy no.: \_\_\_\_\_

Birth date: \_\_\_\_\_ Group no.: \_\_\_\_\_

Customer's relationship to subscriber:     Self     Spouse     Child    Other: \_\_\_\_\_

Name of secondary insurance (if applicable): \_\_\_\_\_ Policy no.: \_\_\_\_\_

Subscriber's name: \_\_\_\_\_ Group no.: \_\_\_\_\_

Customer's relationship to subscriber:     Self     Spouse     Child    Other: \_\_\_\_\_

**IN CASE OF EMERGENCY**

Name of local friend or relative (not living at same address): \_\_\_\_\_

Relationship to Customer: \_\_\_\_\_ Home phone no.: \_\_\_\_\_ Work phone no.: \_\_\_\_\_

I understand that I am responsible for any charges not covered by my insurance. I understand it is my responsibility to inform this office of any changes in my insurance coverage. Failure to inform this office of correct primary and secondary insurance coverage makes it impossible to obtain required referrals and pre-certification. This may result in my being responsible for the entire charge. I authorize the release of any medical information to (1)any insurance company through which I claim benefits and (2)any physicians as requested by any such insurer or physician. I authorize the assignment of all medical and procedural benefits to which I am entitled, including Medicare, Private Insurance, group benefits, and other health plans to Alala, LLC. As this boutique does not extend credit, I understand it is my responsibility to pay all collection costs and reasonable attorney's fees in the event this account is turned over to an attorney for collection.

Customer/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_