

PATIENT INFORMATION

PLEASE COMPLETE ALL LINES. WE NEED THIS INFORMATION BEFORE WE SEE YOU.

First Name: _____ MI: _____ Last: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: ____ / ____ / ____ Sex: M F Home Phone: (____) _____

Social Security # _____ Marital Status: _____

Employer: _____ Work Phone: (____) _____

Student: Full Time Part Time (Please check one for insurance purposes.)

In case of EMERGENCY, who should we notify? _____

Emergency contact's phone (____) _____

Primary Care Physician: _____ Phone (____) _____

Referring Physician: _____ Phone (____) _____

How did you hear about us? (Please be specific. For example, tell us which newspaper, yellow page directory, etc.)

Newspaper: _____ Website: _____ Radio: _____ Health Fair: _____

Yellow pages: _____ TV: _____ Cancer Screening: _____ Lecture: _____

Relative/Friend: _____ Address: _____ City/Zip: _____

PARENT OR RESPONSIBLE PARTY

Name: _____

Address: _____

Home Phone: (____) _____ Work Phone: (____) _____

SS#: _____ Date of Birth: ____ / ____ / ____ Sex: M F

Relationship: _____ Employer: _____ Address: _____

PLEASE TURN TO THE BACK SIDE FOR NEEDED INSURANCE INFORMATION.

PLEASE PRESENT INSURANCE CARDS TO THE RECEPTIONIST SO COPIES MAY BE MADE.

INSURANCE INFORMATION

(This information is in regard to the person whose name appears on the insurance card.)

Primary Ins. Name: _____

Secondary Ins. Name: _____

Name of Insured: _____

Name of Insured: _____

Insured's SS# _____

Insured's SS# _____

Insured's Date of Birth: _____

Insured's Date of Birth: _____

Insured's ID#: _____

Insured's ID#: _____

Group#: _____

Group#: _____

Employer Name: _____

Employer Name: _____

- I authorize the release of medical information necessary to process this claim and also authorize the payment of medical benefits to the physician.

SIGNATURE: _____ DATE: _____

PAYMENT POLICIES

- In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. **IN THE EVENT YOU DO NOT CARRY INSURANCE PAYMENT IS REQUIRED FOR ALL SERVICES AT THE TIME THEY ARE RENDERED.** We accept payment in the form of cash, check or credit card.
- In the event of hospitalization or major procedures, our office will file the appropriate insurance. However, before such claims are filed, **COVERAGE MAY BE PRE-VERIFIED AND YOU WILL BE ASKED TO PAY ANY UNMET DEDUCTIBLES, NON-COVERED SERVICES AND CO-PAYMENTS.**
- On any amount not paid when due **PATIENT SHALL PAY ANY AND ALL COSTS OF COLLECTION OF ANY PAST DUE SUMS INCLUDING ATTORNEY FEES, COLLECTION FEES, AND CONTINGENT FEES TO COLLECTION AGENCIES OF NOT LESS THAN 35%....** Your signature below signifies your understanding and willingness to comply with this policy.

PATIENT'S OR GUARANTOR'S SIGNATURE: _____ **DATE:** _____

MEDICARE / MEDICAID AUTHORIZATION

- PLEASE SIGN SO WE MAY HAVE YOUR MEDICARE AUTHORIZATION ON FILE: I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, its intermediaries or carrier any information needed for this or any related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment or benefits apply.

PATIENT'S OR GUARANTOR'S SIGNATURE: _____ **DATE:** _____

SUPPLEMENTAL AUTHORIZATION

- PLEASE SIGN SO WE HAVE YOUR SUPPLEMENTAL AUTHORIZATION ON FILE: I request authorized MEDIGAP benefits to be made on my behalf for any service furnished to me. I authorized any information needed to determine these benefits payable for related services.

PATIENT'S OR GUARANTOR'S SIGNATURE: _____ **DATE:** _____