Stuart Family Practice Center
Patient Update sheet

Please help us to ensure that your address and phone numbers, and insurance information are accurate
(It is mandatory that this information is updated yearly)

Date:____________________

Name:____

Address:____

____

Home:_________________________ Cell:__________________________SSN:__________________________

Employer:___________________________ Work phone: ____

Email Address:____

Preferred Method of contact: phone mail web message

Emergency Contact

Name:______________________________Phone: ________________________Relationship:______________

Insurance:____________________________Policy#:________________________Group:____________________

Please be advised that you must notify this office in writing if you need you change your HIPPA information. Not updating your information may result in situations out of the control of the office. If you are divorced, separated or newly married, please update your HIPPA information to prevent any delay in your care.

I understand that I am financially responsible for any balance not covered by my insurance and if my account becomes delinquent and is sent to collections for non payment over 90 days, I will be charged a 25% collection fee of the balance due. I hereby direct payment of surgical/medical benefits to Dr. Richard B. Weisberg for services rendered at Stuart Family Practice. I certify that the information listed above, given by me is true and correct. I request payment for authorized benefits be made on my behalf. I understand that it is my responsibility to notify the office of any demographic and insurance changes at the time of service and failing to do so may results in me being billed directly for services.

Patient signature:____

Parent/Guardian:____

This update form is effective for 1 year from the date signed, unless changes occur prior to that date at which time a new update form will replace this one.