PATIENT INFORMATION

Name_____

(First) (Middle) (Last)

Mailing Address_____

City,State,Zip_____

Phone #:_____ Work Phone #:_____

Email address:_____

Sex: Male/Female Married/Widowed/Single/Divorced **Employed: Yes/No**

Employers Name and Address_____

Date Of Birth:_____ Social Security#:_____

Insurance Information

Primary Insurance:_____

_____

Secondary Insurance:_____

_____

Person to Contact in Case of Emergency

Name_____ Relationship_____

Phone Number_____

Referring Physician_____

FINANCIAL POLICY

We strongly feel all patients deserve the very best medical care that we can provide. Everyone benefits when financial arrangements are agreed upon.

Our professional services are rendered to you, not the insurance company. Payment for treatment is your responsibility.

Financial agreements

Initial

_____I have no insurance coverage. I understand that I am responsible for payment of services rendered to myself or dependents at the time of service.

_____I understand if I fail to pay amounts owed: the clinic has the right to secure an outside collection agency and/or attorney to collect the unpaid debt and to report the unpaid debt to a credit-reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collection agency or attorney, including reasonable attorney's fees.

Insurance Authorization and Assignment

_____I hereby authorize the release of any information necessary to process insurance claims and request payment of benefits to be made for services rendered to my dependents or myself.

_____I understand I am responsible at the time of service for paying any required co-payment and deductible.

Medicare_____I authorize any holder of medical or other information about me to release to the social security administration and health care finance administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of nay other party who may be responsible for paying for my treatment. (Section 1128B of the social security act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaing to medicare assignment of benefits also apply.

Medigap_____I authorize any holder of medical or other information about me to be released to process this mediap claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or the party who accepts assignment.

There will be a $25.00 charge on all returned checks.

I have read and understand the payment policy of this office and agree to abide by the said policy.

Signature_____Date_____