**Patient Account Record**

Last Name:

**Patient Name (Last,First) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_**

**Responsible Party (if not patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Complete Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Payment can be made using cash, check, credit card, HSA (Health Spending Account or other work “benefits” debit cards). $25 fee will be assessed for returned checks. Repeat credit card declines will require alternate payment method. Please complete the information below and print clearly to avoid errors. Thank You. \*This information, when entered electronically, is secured by HIPAA compliant encrypted technology; once electronically entered your CVV code is not stored on paper. We also take extra measures to protect your health and billing information; any paper records are secured and stored behind 3 secure locked doors.**

**PLEASE PRINT CLEARLY TO AVOID ERROR THANK YOU!**

**Credit Card #1 Name on card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Number: \_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Exp. Date\_\_\_\_\_\_\_\_\_CVV Code \_\_\_\_\_\_\_\_\_\_\_ Billing Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Credit Card #2 Name on card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Number: \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Exp. Date\_\_\_\_\_\_\_\_\_CVV Code \_\_\_\_\_\_\_\_\_\_\_ Billing Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Visit CPT Code Fee Adjustment Charge Paid Balance Pay Method Other**

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