2020 – PT UPDATE: Date: ________________________

(Please Print Clearly)

Name ____________________________ ____________________________________ ______________
Last First Middle Initial

Address ______________________________ Sex: **M** **F**

____________________________________ Date of Birth _____ / _____ / _____

____________________________________ SS# ______ / ____ / ______

Check Preferred method of automated reminder calls:
____ 1) message on Home #
____ 2) message on Cell #
____ 3) text message on Cell #

Home Phone _________________________ Cell Phone _________________________

EMAIL ADDRESS: ____

INSURANCE INFORMATION:

Primary INS ______________________________ Member ID# ______________________________

* Policy Holder _____________________________ Relationship to patient _____________________

Date of Birth ______ / ______ / _______ Employer ______________________________

* Secondary INS ____________________________ Member ID# ____________________________

I have provided a copy of the front and back of my insurance card **X** _________________

Patient's Initials

Individuals that I approve to share information with:

Name	Relationship to patient	Phone #

Primary Care Physician ___________________________ May we communicate with PCP? Yes / No

Credit Card information to be on file: Name as appears on card: _____________________________

________ ________ ________ ________ Expiration _____ / ______ Security Code ________

REMINDERS:

- I am aware that should I cancel under 24 hours prior to an appointment, and/or No show for my appointment, there is a fee that is *my responsibility* and is not billable to my insurance.

  X ________________
  Patient's Initials

- Should I request medication refills in between appointments, I understand there is a $20 fee for this service .

  X ________________
  Patient's Initials

I AUTHORIZE & ACCEPT RESPONSIBILITY FOR PAYMENT ON THIS ACCOUNT

X ____________________________________