

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 _____

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:

<u>Name</u>	<u>Relationship to patient</u>	<u>Phone #</u>
_____	_____	_____
_____	_____	_____

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 _____