WELCOME

Thank you for selecting our healthcare team! We will strive to provide you with the best possible health care. To help us meet all your heathcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

1 Patient Information

Date _____

Birthdate _____

Name of Patient _____

Wishes to be called _____

☐ Male ☐ Female

Address _____

City _____ State/ Prov _____ Zip/ PC _____

PCP _____

2 Responsible Party

Who is responsible for the account?

Name _____

Relationship to patient _____ Legal Guardian _____

Birthdate _____ Driver's License # _____

SS #/SIN _____

Address _____ E-Mail _____

City _____ State/ Prov _____ Zip/ PC _____

Employer _____

Occupation _____

Work Phone _____ Ext. # _____

Home Phone _____ Cell Phone _____

Email _____

Pharmacy Name & Address _____ Pharmacy Phone _____

3 Telephone

Home Phone _____

Work Phone _____ Ext. # _____

Cell Phone _____

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Cell

When is the best time to reach you? Time _____ Days _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____ Work # _____ Home # _____

4 Insurance Information

Primary Insurance

Name of Insured _____

Relationship to patient _____

Insured's birthdate _____

SS #/SIN _____

Employer _____

Date employed _____

Occcupation _____

_____

Insurance Company _____

Group # _____

Employee/Cert.# _____

Ins. Co. Address _____

Voicemail ok to leave normal test results _____
Initial

For HIPPA paperwork check:

_____ YES, if you want a copy

_____ NO, if you don't want a copy

Missed appointment is $50 if you don't call and cancel in 24 hours _____
Initial

Late Charges is $15 _____
Initial

5 Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

X _____

Signature of patient or parent/guardian if minor Date

6 Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.

_____ Cash

_____ Personal Check

_____ Credit Card ____ Visa ____ MC

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of $15 on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is a prepayment for additional services. In case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask - we are always happy to help.