PATIENT INFORMATION FORM

PATIENT'S NAME(LAST)_____(FIRST)_____(M.I.)_____

ADDRESS_____CITY_____STATE____ZIP CODE_____

HOME PHONE_____CELL_____

DATE OF BIRTH_____AGE_____SEX_____

SOCIAL SECURITY NUMBER_____MARITAL STATUS_____

EMPLOYER_____
(NAME) (ADDRESS) (CITY/ST/ZIP)

May we contact you at work? YES NO WORK NUMBER_____

RESPONSIBLE PARTY(LAST)_____(FIRST)_____(M.I.)_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____CELL_____

DATE OF BIRTH_____AGE_____SEX_____

SOCIAL SECURITY NUMBER_____MARTIAL STATUS_____

PRIMARY INSURACE

_____
(Primary Insurance Company Name) (ID#) (Group #)

_____
(Address) (City,State,Zip) (Phone)

_____
(Policy Holder Name) (ID#) (Date of Birth)

(Copy of insurance card required)

SECONDARY MEDICAL INSURANCE

_____
(Primary Insurance Company Name) (ID#) (Group #)

_____
(Address) (City,State,Zip) (Phone)

_____
(Policy Holder Name) (ID#) (Date of Birth)

(Copy of insurance card required)

ALPINE FAMILY PRACTICE

EMERGENCY CONTACT INFORMATION

(Name) (Phone) (Relationship)

(Address) (City) (State) (Zip)

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

X _____
Patient/Responsible Party Signature DATE

AGREEMENT TO PAY FOR TREATMENT

I, THE RESPONSIBLE PARTY LISTED BELOW, HEREBY AGREE TO PAY ALL CHARGES SUBMITTED BY THIS OFFICE DURING THE COURSE OF TREATMENT FOR THE PATIENT. If the patient has insurance coverage with a managed care organization with whom this office has a contractual agreement, I agree to pay all applicable co-payment and deductibles which arise during the course of treatment for the patient. Co-pays are expected to be paid at the time of service. The responsible party also agrees to pay for treatment rendered to the patient which is not considered to be a covered service by third party insurers or payors.

"No show Policy" - If a patient makes an appointment and fails to show up or cancel the appointment at least one hour in advance they will be considered a "no show" for that visit. Insured patients who have two "no show" visits at the clinic will be charged a $25.00 no show fee for every "no show" thereafter. This will not be paid by insurance and is the patients' responsibility. We have adopted this policy in an effort to be able to see sick patients as quickly as possible.

Check policy - All bounced checks to Alpine Family Practice will be retrieved through electronic payment systems. There will be a fee to the patient for this recovery service.

Collection Policy – If a patient is sent to collections for failure to make payment or if patient declares bankruptcy they will be expected to pay all charges in advance at future appointments. If a patient is sent to collections a second time they (and anyone they are financially responsible for) will be dismissed from the clinic.

X _____
Responsible Party DATE

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER

I, understand responsible party hereby authorize this office/its employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I, authorize the release and disclosure of any and all of my child's medical records to any other entity, including, but not limited to specialty physicians, hospitals, or other health care providers which may be assistance in the opinion of this office, in providing treatment of the patient.

I, authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled.

I, authorize the office and/or its employees to release, via fax machine, medical records which are needed in ordered to provide the patient with the most appropriate medical care.

I, authorize and request the payment of my third party or insurance company benefits be made directly to this office for any services furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

X _____
Responsible Party DATE