

PATIENT INFORMATION

Name: _____
(First) (Middle) (Last)
Mailing Address: _____ City: _____ State: _____ Zip: _____

Sex: Male / Female
(Please Circle One)

Employed: Yes / No
(Please Circle One)

Employer's Name & Address: _____
Occupation: _____
Residence Telephone: _____ Work Telephone: _____
Date of Birth: _____ Social Security #: _____
Marital Status: Single Married Separated Divorced Widow/Widower
(Please Circle One)

BILLING INFORMATION

Person responsible for paying bill: Patient Parent Spouse Other: _____
(Please Circle One)
Name (if different from above): _____ Date of Birth: _____
Address (if different from above): _____
Residence Telephone: _____ Work Telephone: _____
Occupation: _____
Employer's Name & Address: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Company's Name Address, City, State, Zip Code, Telephone Number

Subscriber's ID Number Group Number Policyholder's Name Social Security #

Patient's relationship to policyholder: Self Spouse Child Other Date of Birth of Subscriber: _____

SECONDARY INSURANCE

Insurance Company's Name Address, City, State, Zip Code, Telephone Number

Subscriber's ID Number Group Number Policyholder's Name Social Security #

Patient's relationship to policyholder: Self Spouse Child Other Date of Birth of Subscriber: _____

Person to contact in case of emergency

Name: _____
Address: _____
Telephone Number: _____ Relationship: _____

Was this an accident: ___ Yes ___ No If so indicate: ___ Auto ___ Workers' Comp ___ Other

Referring Physician: _____

PLEASE COMPLETE ALL INFORMATION ON THE REVERSE SIDE

FINANCIAL POLICY

We strongly feel all patients deserve the very best medical care that we can provide. Everyone benefits when financial arrangements are agreed upon. We have prepared this material to acquaint you with our policy. Our professional services are rendered to you, not the insurance company. Payment for treatment is your responsibility.

FINANCIAL AGREEMENTS

Initial

____ I have no insurance coverage. I understand that I am responsible for payment of services rendered to myself or dependents **at the time of service**.

____ I understand if I fail to pay amounts owed; the clinic has the right to secure an outside collection agency and/or attorney to collect the unpaid debt and to report the unpaid debt to a credit-reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collection agency or attorney, including reasonable attorney's fees.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Initial

____ I hereby authorize the release of any information necessary to process insurance claims and request payment of benefits to be made for services rendered to my dependents or myself.

____ I understand I am responsible **at the time of service** for paying any required co-payment and deductible.

MEDICARE/MEDIGAP

For Medicare Patients Only

Medicare Number

____ I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Finance Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignments of benefits also apply.

Medigap Authorization Statement

Policy Number

____ I authorize any holder of medical or other information about me to be released to process this Medigap claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or to the party who accepts assignment.

There will be a \$25 charge on all returned checks.

I have read and understand the payment policy of this office and agree to abide by the said policy.

Patient / Guardian Signature

Date

Please present both your insurance card and your driver's license so we may make a copy for our records.

I will be paying by: ____ Check ____ Cash