PATIENT INFORMATION

Patient Name: ____ Date: ___________
(LAST) (FIRST) (MIDDLE)

SSN: ________________ Date of Birth: ________________ Sex: Male Female

Home Address: ____

Home/Cell Phone: ___________________________ Work Phone: ______________________

Marital Status: ______________ Languages: English Spanish Other: ___________

Primary Care Physician: _____________________________ Phone Number: ______________

How Did You Hear About Our Office: ____

Employer: _________________________________ Phone Number: ____________________

INSURANCE INFORMATION

Insurance Company: ____

Policy Holders Name: ____________________________________ DOB: _________________

Sex: Male Female SSN: ___________________ Relationship: ______________________

Home Address: ____

Patient ID #: ___________________________ Group # (If It Applies): _____________________

EMERGENCY CONTACT/LEGAL GUARDIAN OF PATIENT

Name: ____ Phone Number: ______________

Relationship to Patient: Mother Father Grandparent Other: ________________

FINANCIAL RESPONSIBILITY

Payment is Required at Time of Service:

- Patients who are not covered by health insurance, on a plan that we do not participate with, or if we are not able to verify your coverage, will be responsible and must pay at the time of service. Any unpaid or denied claims become the responsibility of the patient.
- You are responsible for notifying our office if your insurance coverage changes. We have always filed insurance claims for patients; however any unpaid or denied insurance claims over 30 days old is the responsibility of the patient to pay.
- Should your account become severely delinquent, the patient or guarantor agrees to pay all costs associated with the collection efforts including attorney fees, collection fees and contingency fees to collection agency not less than 33%. The contingency fees will be added and collected by the collection agency immediately upon referral of account to the collection agency.
- If you are unable to keep your appointment, you will be required to call out office 24 hours prior to your appointment. You may be charged a fee of $25.00 for no show or late appointment.

I have read and understand the financial policy of the practice and agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

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PATIENT/RESPONSIBLE PARTY SIGNATURE **DATE**