PATIENT INFORMATION

PATIENT NAME (LAST)____________________________(FIRST)__________________________(MI)____________

ADDRESS ____

CITY_________________________________ STATE ________ ZIP CODE________ SS#_________________

HOME PHONE# (   ) ______________________ WORK PHONE# (   ) ___________________________

CELL PHONE # (   ) _________________________ GENDER: F / M D.O.B._____________________AGE_______

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER NAME____

INSURANCE CLAIMS ADDRESS ____

PATIENT INSURANCE ID # ____ GROUP # __________________

POLICY HOLDERS NAME (IF DIFFERENT THEN PATIENT) _____________________________ D. O.B. _____________

POLICY HOLDERS SS # _____________________________ OR SELF____ (CHECK IF PATIENT IS THE POLICY HOLDER)

REFERREL # _____________________________________ REFERRING DR. _________________________________

SECONDARY INSURANCE CARRIER NAME ____

INSURANCE ADDRESS____

PATIENT INSURANCE ID # ____ GROUP # _____________________

POLICY HOLDERS NAME (IF DIFFERENT THEN PATIENT) ____________________________ D. O.B. ______________

EMERGENCY CONTACT NAME ___________________________________PHONE # ___________________________

NOTICE OF PRIVACY STANDARDS HEALTH INSURANCE FORTABILITY AND ACCOUNTABILITY ACT (HIPPA) BY SIGNING BELOW I ACKNOWLEDGE THAT I AM AWARE OF THE HIPPA ACT AND AM AFFORDED THE OPPORTUNITY TO REVIEW THE NOTICE OF PRIVACY PRACTICES.

SIGNATURE ____ DATE__________________________

IN ORDER TO ESTABLISH OPTIMAL RELATIONS WITH OUR PATIENTS AND AVOID MISUNDERSTANDINGS, OUR STAFF IS TRAINED TO CONSISIENTLY INFORM YOU OF THE FINANCIAL PAYEMENT POLICIES OF THIS OFFICE. PAYMENT OF COPAYS IS DUE AT THE TIME OF VISIT. PAYMENT MAY BE MADE IN THE FORM OF CASH OR CHECK. PATIENTS WITH DEDUCTABLES WILL BE BILLED ACCORDINGLY AS INDICATED ON THE EXPLANATIONS OF BENEFITS FROM YOUR INSURANCE CARRIER. NON INSURED PATIENTS ALL FEES FOR SERVICES RENDERED IS DUE AT THE TIME OF VISIT UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE WITH THE OFFICE MANAGER. YOUR SIGNITURE BELOW SIGNIFIES YOUR UNDERSTANDING AND ACCEPTENCE OF THIS POLICY.