

PATIENT INFORMATION

Date: _____ Were you referred? Yes No Referring Doctor: _____

Patient Name: _____ Sex: M F Age: _____ Birthdate: ___/___/___

Patient Address: _____
Address City State Zip

Patient SSN: ___-___-_____ Home Phone: _____

Address of Insured: _____

Parent or Legal Guardian Name: _____ Parent or Legal Guardian Employer: _____

Parent or Legal Guardian Phone #: _____ Phone # of Insured: _____

IN CASE OF EMERGENCY, CONTACT: Name: _____ Relation to Patient: _____

Emergency Contact's Home Phone: _____ Emergency Contact's Work Phone: _____

INSURANCE INFORMATION

PAYMENT POLICY: Self Pay: YES or NO VSP: YES or NO

Self paying patients must pay in full at the time of the visit. Insurance will be verified and accepted, however, the co-pay, deductible, and/or charges not covered must be paid in full at the time of the visit.

IMPORTANT: We are unable to bill your insurance without a copy of your insurance card.

PRIMARY INSURANCE Insurance Co.: _____ Group Name or # _____

Insurance Co. Address: _____ Phone #: _____

Subscriber Name: _____ Subscriber Birthdate: ___/___/___ I.D. or SSN (REQUIRED): _____

Patient's relationship to Subscriber: _____

SECONDARY INSURANCE Insurance Co.: _____ Group Name or # _____

Insurance Co. Address: _____ Phone #: _____

Subscriber Name: _____ Subscriber Birthdate: ___/___/___ I.D. or SSN (REQUIRED): _____

Patient's relationship to Subscriber: _____

FINANCIAL POLICY REGARDING INSURANCE:

1. Patients are responsible for all charges regardless of insurance coverage.
2. Patients are responsible for any pre-authorizations and referral forms required for payment.
3. We will not become involved in disputes between you and your insurance company regarding deductibles, covered charges and usual and customary fees.
4. Co-payments and deductibles may be paid in cash or by check, Visa, or MasterCard.
5. Past Due accounts may be subject to a 40% collection fee if referred to a collection agency

PRIVACY POLICY & PATIENT VERIFICATION

I, the patient/guardian, have accurately and truthfully completed the patient information listed above. I agree that all fees incurred are my responsibility regardless of insurance coverage. Furthermore, I certify that I have read and agree to the patient information and privacy policy of this office.

Patient's signature (or parent/legal guardian) Date