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| Patient | | Male | Female | Civil Status: Single | | Married | Widowed | Divorced |
| Full Name | | | DOB | Age | Social Security No. | | | |
| Mailing Address | | | | | | Home Phone | | |
| Employer & Emp Address | | | | | | Work Phone | | |
| Supervisor's Name | | Length of Employment | | Position | | Driver Lic # | | Do you live with Responsible party? Yes No |
| Is this illness Yes | | Has a Workman's Compensation Claim been filed? Yes No | | Date Filed | | Claim Number | | Where filed |
| Responsible Party | | DOB: Male Female | | Social Security No. | | | | Years in area |
| Mailing Address | | | | | Driver Lic # | | Relationship to Patient | |
| Street Address | | | | | Years at this address | | Home Phone | |
| Previous Address If less than 2 yrs at above address | | | | | Email Address | | Years at Previous Address | |
| Employer & Emp Address | | | | | | Work Phone | | |
| Length of Employment Yrs | | Position | | | Name of Supervisor | | | |
| Do you own your own home? Yes No | | If no, Name & Phone No of Landlord | | | | | | |
| Do you have A major credit card? Yes No | | Have you ever had a bill Sent to a collection agency Yes No | | If yes, is it now paid in full? Yes No | | Have you ever Declared bankruptcy? Yes No | | Date: Have you every had Property repossessed? Yes No |
| Spouse of Responsible Party | | | DOB: Male Female | | Social Security No. | | | |
| Full Name | | | | | | Driver Lic # | | |
| Employer & Emp Address | | | | | | Work Phone | | |
| Medical Insurance Information | | | We request that deductibles and co-payments be paid at the time of service. | | | | Is this a Managed Care Policy? Yes No | |
| Primary Insurance MEDICARE | | Medicare ID# | | | | | We do not file secondary insurance. We need the information on file to respond to inquiries. | |
| Secondary Insurance Name & Address | | | | | | Name of Policyholder | | |
| Group No: | | Member No | | Deductible: | | Crossover? Yes No | | |
| Is any of the following required? Referral from primary care physician Prior authorization | | | | | | | | |
| Referring Physician | | | | | | PCP | | |
| Emergency Name, Address & Phone # | | | | | | Relationship to Patient | | |
| <p>Regulation Z of the Federal Truth in Lending Act requires us to state that we operate on a payment at time of visit basis When granted, credit is extended to approved applications on the following terms only: Each patient will have the option to make payment in full within 30 days or make monthly installments in the amount determined by the schedule outlined in our Office Policy (approximately 10% of the unpaid balance). All accounts are subject to a finance charge of ten percent (10%) a year or 0.8333 percent per month on any balances outstanding for 90 days or more.</p> <p>I agree to the above terms and to pay finance charge of 10% per year on balances outstanding 90 days or more. I understand and agree that if it becomes necessary to turn this matter over for collection, the prevailing party shall be entitled to recover reasonable costs including attorney fees together with interest as provided by law on all amounts found due for professional services.</p> <p>I authorize the release of any medical information necessary to process any insurance claim for professional services received.</p> <p>I have read the Office Policy and agree to the provisions contained therein.</p> | | | | | | | | |
| I do not wish credit. I will pay charges in full the same day I see the Doctor. | | | | | | | | |
| Date: _____ | | | Signature _____ | | | | | |
| <p>Consent to Treatment: I consent to treatment as necessary or desirable for the care of the patient named above, including but not restricted to whatever drugs, medicine, performance of operation and conduct of laboratory, x-ray or other studies that may be used by the attending Medical Doctor or qualified designate. It is my understanding that the need for each test, medication and surgical procedure will be fully explained.</p> | | | | | | | | |

