

Type of Visit: (check one)

- Insurance: I will present my insurance ID card at check-in for approval
- Private Pay: I will be paying in full, today, at the time of services
- On-the-job injury

Payment Method: (check one)

- Payment made today will be paid by:
- Cash
 - Visa / MC / Discover

PATIENT NAME AND INFO:

Patient Last Name: _____ First: _____ M.I.: _____
Address _____ APT _____ **Best contact phone** _____
City _____ State: _____ Zip: _____ Other phone _____
Patient SS# _____ Patient Date of Birth: _____ Work phone _____
Gender: Male Female Email: _____

ACCOUNT NAME: (Fill in this portion only if patient is a minor OR if patient is insured through a family member)

If Insurance: This is the **insured Person** (person whose employer offers the Insurance, often the person whose SS# is on the ID card.)

If Private Pay: If patient is a minor, then enter parent's or guardian's information here.

Account Last Name: _____ First: _____ M.I. _____
Account SS# _____ Account Date of Birth: _____ Phone number _____
Patient's Relation to Insured person: Child Spouse

Only Primary Insurance will be billed, please make arrangements with primary insurance to forward information to secondary insurance to avoid being billed for remaining amount. (Medicare with Medicaid secondary will do this automatically).

EMERGENCY CONTACTS: (who should be contacted if patient has a medical emergency)

Name: _____ Relationship to patient: _____ Phone # _____
Name: _____ Relationship to patient: _____ Phone # _____

Complete only if On-the Job Injury:

Company Name: _____ Name of Supervisor who sent you: _____
Company address: (street, city, state, zip): _____
Company phone: _____ If Injury, **exact** date of injury: _____
* Is your employment through a temporary service? Name of Temp Service _____
* Is your employment through an independent contractor? Name of Contractor _____

Authorization for treatment, Assignment of insurance benefits, Guaranty of payment, Release of records:

I consent to the administration and costs of medical and surgical procedures, labs, x-ray, and medication which doctors deem necessary. I authorize the release and transfer of records and information regarding my treatment or medical condition to other providers for treatment purposes, to my insurance carrier and any other payor for payment, to my employer if my treatment is related to employment purposes, for other healthcare operations, and as otherwise set out in the Notice of Privacy Practices, which I do hereby acknowledge receiving. I hereby guarantee payment of all center and physician charges incurred by the the above named patient for this visit (except for an authorized and qualified work related expense). I understand that no guarantee or assurance has been made as to the results, which may be obtained. I give permission to leave messages regarding my care at the Best Contact # listed above. I understand that **I must pay in full today** for all services rendered, unless, my insurance is accepted. I also understand that if my insurance is accepted that I must pay all applicable insurance copays, coinsurances and deductibles in full today. If we are unable to verify your insurance at the time of service, I may be required to pay in full for all services.

Private Pay patients only: I understand that a claim will not be filed on my behalf, now or in the future, even if I acquire health insurance.

Labs and Outside Tests Information:

I understand that if any labs/tests are ordered by the doctor, **I will need to call or come to the office to get all of the results.** Unless I am notified earlier, I promise to call or come to the office within five business days after the tests/labs are performed. I understand that **no call does not mean normal results.**

Patient/Guarantor's Signature _____ **Date** _____