

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
- Auto Accident / Customer Injury / Third Party Property

Payment Method:

- Payment made today will be paid by:
- Cash
 - Check (no temp or post dated)
 - Visa / MC Discover

ACCOUNT NAME:

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: This is the patient, unless the patient is a minor, then the Account Name listed is the parent or guardian.
 If Work Related: This is the patient, even though the company is responsible and is being billed.

Account Last Name: _____ First: _____ M.I.: _____
 (if insurance, this is the name of insured person/ person who carries the insurance)

Street Address _____ Home phone _____

City _____ State: _____ Zip: _____ Other phone _____

Drivers License# _____ Account SS# _____ Work phone _____
 (If insurance, SS# of the insured person)

PATIENT NAME AND INFO: Must complete even if same as above.

Patient Last Name: _____ First: _____ M.I. _____

Patient SS# _____ Patient Date of Birth: _____ Phone number _____

Gender: Male Female Email: _____

Relation to Insured person: Self Child Husband Wife

EMERGENCY CONTACTS

Last Name: _____ First Name _____ Phone # _____

Last Name: _____ First Name _____ Phone # _____

Complete only if using Insurance that is accepted:

Employer of Insured person: _____

Insured Date of Birth: _____

Do you have insurance with more than one health plan? Yes No

If yes: Name of other insurance company: _____ (Present both of your ID cards at front desk)

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, 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 of assurance has been made as to the results, which may be obtained. I give permission to leave messages regarding my care at the home # 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, you may be required to pay in full for all services.

Patient/Guarantor's Signature _____ Date _____