LAST NAME:_________________________ FIRST NAME:_____________________BIRTDATE: _____/_____/_________

ADDRESS:____CITY:_________________STATE:______ZIP:__________

SSN:_______/________/____________ [__]Male [__]Female PHONE:(________)____________________

E-MAIL ADDRESS: _______________________@ ______________

MARITAL STATUS: [__]Single [__]Married [__]Divorced [__]Widow [__]Other: _____________________

PREFERRED LANGUAGE: [__]English [__]Tagalog [__]Spanish [__]Other: _____________________

RACE: [__]American Indian or Alaska Native [__]Asian [__]Black or African American [__]White
[__]Hispanic [__]Other [__]Unreported/ Refuse to Report

EMPLOYER:_____________________________PHONE:(____)_____________OCCUPATION:______________________
EMPLOYER ADDRESS:__________________________CITY:______________________STATE:_______ZIP:___________

GUARANTOR INFORMATION

NAME OF RESPONSIBLE PARTY:____________________________________RELATIONSHIP:____________________

DATE OF BIRTH:____/____/________SSN: _______/__________/__________ PHONE:(_______)______________________

ADDRESS:____CITY:__________________STATE:______ZIP:_________
EMPLOYER:________________________PHONE:(_____)______________ OCCUPATION:________________________

EMERGENCY INFORMATION

PERSON TO NOTIFY IN CASE OF EMERGENCY:____
RELATIONSHIP:_________________________________ PHONE:(_____)______________________________

INSURANCE INFORMATION

PRIMARY INSURANCE:___________________________POLICY#___________________ GROUP#_________________

INSURED NAME:____________________________________ INSURED DATE OF BIRTH: _____/_____/_________

PATIENT RELATIONSHIP TO THE INSURED: [__]Self [__]Spouse [__]Natural Child [__]Other: _____________

SECONDARY INSURANCE:__________________________POLICY#___________________GROUP#________________

INSURED NAME:____________________________________ INSURED DATE OF BIRTH: _____/_____/_________

PATIENT RELATIONSHIP TO THE INSURED: [__]Self [__]Spouse [__]Natural Child [__]Other: _____________

READ AND SIGN BELOW

The above information is complete and correct. ***AUTHORIZATION AND ASSIGNMENT OF BENEFITS:*** I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the physician or group indicated on the claim. I understand that I am responsible for any deductibles, co-payments or amount for services not covered by my insurance plan. All professional services rendered are charged to the patient, or guarantor, if a minor. In the event of collection proceedings due to lack of payment, there may be additional charges for any and all collection fees. A copy of the signature is as valid as the original. I further agree to allow provider to access the prescription history for treatment of the patient.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY:__________________________________ DATE: _____________

PLEASE READ CAREFULLY

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We ask that all patients take a few moments and review our financial policy, initial each item. Should you have any questions, please do not hesitate to request to speak with our billing company.

________ ***Cash Patients:*** payment for services is due at the time services are rendered. We accept cash, checks by mail, Visa and Mastercard.

________ ***Insured Patients:*** co-payments, co-insurances, and/or deductibles are due at the time services are rendered. We accept cash, checks by mail, Visa and Mastercard.

________ If your insurance company does not pay your claim within 45 days we ask that you contact your insurance company to help get your claim (s) for services paid. You are ultimately responsible for the payment of services.

________ Returned checks are subject to a $20 returned check fee. If a check is returned, unpaid, it is the patient or guarantors responsibility to pay the balance, including the returned check fee, within 10 business days of notification to avoid further collection activity.

________ Delinquent accounts may be turned over to a collection agency. Our billing department will send three (3) patient statements for balances due. The fourth (4th) patient statement can be a pre-collection statement. This may be the final notification prior to collection activity. In the event the account is sent to a collection agency, the patient or guarantor will be responsible for a $50.00 collection fee and all reasonable collections costs.

________ ***No Call No Show for Office Visit:*** If need to cancel your appointment please notify us within 24 hours prior to your schedule. Otherwise, you may be assessed a $20 fee on the third no call no show.

I have read and understand this Financial Policy.

____ _____________________

Signature of Insured/Guarantor/Patient Date

ELIGIBLITY WAIVER

I ____ hereby certify that I am eligible for

Name of Patient

____ as of ___________________________.

Name of Insurance Effective Date

I understand that if I am not eligible, I will be financially responsible for all services rendered to me, and as billed to this insurance company. If I am not eligible for coverage, I agree to pay these services in full within thirty (30) days of notification.

____ _____________________

Signature of Insured Date