

## Patient Information

Name: \_\_\_\_\_ (Age) \_\_\_\_\_ Gender: M F  
Home Address: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
Email Address: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Marital Status: S M D W  
Occupation: \_\_\_\_\_ Employer Name: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
How were you referred to this office? \_\_\_\_\_

**Primary Insurance Company** \_\_\_\_\_ Policy# \_\_\_\_\_  
Phone # ( ) \_\_\_\_\_ Group# \_\_\_\_\_ Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Insured's Name \_\_\_\_\_ Insured's Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Secondary Insurance Company** \_\_\_\_\_ Policy# \_\_\_\_\_  
Phone # ( ) \_\_\_\_\_ Group# \_\_\_\_\_ Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Insured's Name \_\_\_\_\_ Insured's Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Relationship to the insured \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employer \_\_\_\_\_

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from this clinic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically be transferred to your credit card or the extended payment plan.

### *ITEMIZED RECEIPTS, aka. "SUPERBILLS"*

*Our fees and charges are based on the cost of doing business and providing patients with the highest quality of care possible. This office does not participate with any insurance provider or accept such an assignment. Patients are responsible for payment of any services provided. You will be given a receipt with a description of services received, more commonly referred as a "superbill", along with the related charges that you, in turn, can submit to your own insurance company for possible reimbursement, as well as retain for your personal records.*

### DECLARATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services?  Yes  No

Patient's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## In Case of Emergency

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_