PLEASE FILL OUT COMPLETELY AND SIGN WHERE INDICATED. PLEASE PRINT CLEARLY USING BLACK INK.

INSURANCE AUTHORIZATION AND ASSIGNMENT. STATEMENT OF RESPONSIBILITY.

PLEASE SIGN BY THE THREE X'S. WE MUST HAVE YOUR SIGNATURE IN ALL THREE PLACES. A COLLECTION FEE IS ADDED TO ALL DELINQUENT ACCOUNTS SENT TO A COLLECTION AGENCY.

1. **I authorize the release of any medical information necessary to process this claim and all future claims.**
   X_____
   Signed by patient
2. **I authorize payment of medical benefits to undersigned physician or supplier for these services and all future claims.**
   X_____
   Signed (Insured or Authorized Persons)
3. **I hereby acknowledge that the *fundamental responsibility* for payment of my medical bills rest with me. I agree to assume responsibility for all my charges that are denied, or not covered within ninety days of the date of service, by my insurance.**
   X_____
   Signed by patient

PATIENT INFORMATION:

Last Name _____ LEGAL First Name _____ LEGAL Middle Name/Initial _____ Nickname, if any _____

Street Address (including apartment number) _____ City _____ State _____ Zip Code _____

Soc. Sec. No.___-_____-_____ Date of Birth____/_____/_____ Age____ Home No. (____)_____-_____

Employer_____ Occupation_____ Work No. (____)_____-_____

Patient's Marital Status (circle one) Single Married Divorced Widowed Other_____ Cell No. (____)_____-_____

OK to leave messages? Y / N

e-mail address: _____ Ethnicity:_____

Primary Care Physician: _____ **PCP Phone Number:** _____

Referred By: _____ **Insurance Carrier:** _____

RESPONSIBLE PARTY INFORMATION: (If different than patient)

Last Name _____ First Name _____ Middle Name/Initial _____ Nickname, if any _____

Soc. Sec. No.___-_____-_____ Date of Birth____/_____/_____ Phone No. (____)_____-_____

Signature of Responsible Party:_____

POLICYHOLDER INFORMATION: Who is the policyholder? (circle appropriate choice) **YOURSELF SPOUSE OTHER**

If AND only if – the policyholder is "other", please provide the following about the policyholder:

Last Name (of Policyholder) _____ First Name _____ M.I. _____ Relationship to Patient _____

Soc. Sec. No.___-_____-_____ **DOB:** _____ (Very important to have insured's DOB)

EMERGENCY CONTACT INFORMATION: Please give the name of the person you wish for us to contact in case of an emergency.

Last Name _____ LEGAL First Name _____ Relationship to patient _____ Phone No. (____)_____-_____

Information we are authorized to release: ALL ___ OR specify information _____

OFFICE POLICY PLEASE BE PREPARED TO PAY YOUR COPAYMENT, IF REQUIRED BY YOUR INSURANCE, AT EACH APPOINTMENT. WE ALWAYS APPRECIATE IT IF YOU CAN PAY THE UNINSURED PORTION OF OUR CHARGES AT THE TIME SERVICES ARE RENDERED.

INSURANCE INFORMATION WE MUST HAVE A COPY OF YOUR CURRENT INSURANCE IDENTIFICATION CARD. YOU ARE RESPONSIBLE FOR INFORMING US ABOUT ANY CHANGES IN YOUR INSURANCE.

TODAY'S DATE: _____ **RENEWAL DATES:** _____ _____ _____

Preferred pharmacy: _____ **Pharmacy Location:** _____

Pharmacy phone number if known: _____