

## Patient Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_ Preferred Name \_\_\_\_\_  
 Birth Date \_\_\_\_\_ SSN \_\_\_\_\_  Male  Female  Single  Married  Separated  Divorced  Widowed  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Email Address \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

We routinely confirm appointments. Please mark which method you prefer when confirming appointments:  
 Voice - Home Phone  Voice - Cell Phone  Text Message\*  E-mail \*Standard text messaging rates apply.

## Responsible Party (If someone other than patient) Spouse Parent Guardian

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_ Preferred Name \_\_\_\_\_  
 Birth Date \_\_\_\_\_ SSN \_\_\_\_\_ Email Address \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

## Insurance Information Please present your insurance card(s) to the receptionist.

Primary Subscriber Name \_\_\_\_\_ Primary Policy Number \_\_\_\_\_ Primary SSN \_\_\_\_\_  
 Primary Insurance Company Name \_\_\_\_\_ Address \_\_\_\_\_  
 Employer \_\_\_\_\_ Group # (if any) \_\_\_\_\_ Employer's Address \_\_\_\_\_  
 Secondary Subscriber Name \_\_\_\_\_ Secondary Policy Number \_\_\_\_\_ Secondary SSN \_\_\_\_\_  
 Secondary Insurance Company Name \_\_\_\_\_ Address \_\_\_\_\_  
 Employer \_\_\_\_\_ Group # (if any) \_\_\_\_\_ Employer's Address \_\_\_\_\_

## Financial Policy My preferred payment method(s): Cash Check Visa/MC CareCredit

### Mark As Read

- Payment/Insurance Co-Pays:** Due at time of service (unless special financial arrangements are made in advance).
- Payment Plans:** We offer several different payment options from interest free to fixed rate.
- Insurance:** As a courtesy, we only require your estimated co-pay at time of service. We then submit your remaining balance to the insurance carrier for you; the carrier will make any eligible payments directly to our office. In the event that insurance will not pay, you are still responsible for the remaining balance.
- Account Balances:** If you fail to fulfill any financial agreements or obligations, interest will be charged on past due balances at a rate of 1.5% per month (18% APR). If sent to collections, you agree to pay all related legal fees including 33.33% of the amount owed plus all other costs of collection, including court costs.
- Appointments:** If you must change appointments, give at least 24 hours notice to avoid a \$50.00 cancellation fee.

I verify that the information I have provided is true and accurate and I will update this office as changes occur. I have read, understand, and agree to follow the Financial Policy stated above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_