PATIENT INFORMATION ( )New patient ( )Name Change ( )Address Change ( )Insurance Change

THIS SECTION MUST BE COMPLETE FOR ALL PATIENTS: Today's Date____/____/____

Name _____
Last First M.I.
Date of Birth ____/____/____ Age_____ Social Security #_____ Sex: Male ____ Female ____

Marital Status: ( )Single ( )Married ( )Divorced ( )Widowed ( )Separated

ADDRESS:

Home Address _____
City State Zip
Mailing Address _____
(If different from home address) City State Zip
Home Phone (_____) _____ Cell Phone (_____) _____

Pharmacy Phone (_____) _____ Email Address:_____

Employer Name: _____ Patient's Occupation: _____

Employer Address: _____ Work Phone: (_____) _____

Referred By:_____ Primary Care Physician_____

In case of Emergency, who should be notified? _____ Phone (_____)_____

PARENT, SPOUSE, OR RESPONSIBLE PARTY **(if different from patient)**

Name _____
Last First M.I.
Address_____
City State Zip
Home Phone (_____) _____ Work Phone (_____)_____

Date of Birth____/____/____ Sex_____ SS#_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Noticed of Privacy Practices).I have been given the option of signing a separated Patient Consent Form.

Patient or Responsible Party Signature_____ **Date**_____

Payment Policy

Medicare: We are participating provider of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual $100.00 deductible and paying for the 20% co-payment. We do file with secondary / supplemental carriers. However, in the event that the secondary does not pay within 60 days, patient will be balance billed.

Note: If you have recently joined or changed to a Medicare HMO, please let our staff know so we can update you records and advise you if we are participating provider.

HMO, PPO or other managed care patients: You will be responsible for paying your annual deductible, co-payment and charges for any non-covered, cosmetic service.

Commercial patients: Patient who are covered by private, commercial plans in which our physicians are not providers will be required to pay 35% of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of the carrier.

Patient or Responsible Party Signature _____ **Date** _____