PATIENT INFORMATION

Patient Name _____ **Gender**_____ **DOB**_____ **Age**___
Address_____ **Home Phone** _____
City_____ **State** _____ **Zip**_____
Alt/Cell # _____ **Email** _____
Race (circle one): Am. Indian Asian Black/Afr.Am. Nat. Hawaiian Other White
Ethnicity (circle one): Hispanic/Latino Not Hispanic/Latino Unknown
Preferred phone (circle one): HOME CELL Other _____
Parent/Guardian (if patient is a minor):

Father:_____
Address_____
City_____
State_____ Zip_____
DOB: _____
CELL/ALT # [redacted]

Mother_____
Address_____
City_____
State_____ Zip_____
DOB_____
CELL/ALT# [redacted]

Emergency Contact: _____ Phone_____
Relationship to patient: _____

Referring Physician: _____
Address: _____ Phone_____
City _____ State____ Zip_____
Primary Care/Pediatrician: _____
Address: _____ Phone _____
City _____ State _____ Zip_____
PREFERRED PHARMACY _____ Phone: _____
Address: _____ City _____

INSURANCE INFORMATION:
Primary :_____
Card Holder: _____ **DOB:** _____

Secondary: _____
Card Holder: _____**DOB:** _____

Financial Agreement and Authorization for Treatment

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for myself and members of my family, upon presentation thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing in thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the court determines proper.

It is agreed that payments will not be delayed or withheld because of my insurance coverage or the pending claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the correction thereof. (A copy of this assignment is as valid as the original). Rebilling fees will be applied to unpaid balances.

I authorize the provider to release an medical records requested by my insurance company to process my claim.

NOTICE: Do not sign this agreement before you read and agree to the conditions set forth. You are entitled to a copy of the agreement at the time you sign. Keep it to protect your legal rights.

SIGNATURE: _____Today's Date: _____
(Responsible Party)

(revised 9/14/12)