PATIENT INFORMATION SHEET

Today's Date _____

PATIENT INFORMATION

Full Name: _____ Date of Birth: _____ Age: _____ Sex: ____

Address: _____ Social Security #: _____

City, State, Zip: _____ Married ___ Single ___ Widowed ___ Other _____

Home Phone #: _____ Referring Provider: _____

Alternate Phone #: _____ Primary Provider: _____

Patient's Employer and Phone #: _____
Patient's Employer Address: _____
Patient's Emergency contact phone # and Relationship: _____
Email Address: _____

RESPONSIBLE PARTY (if same leave blank)

Full Name: _____ Date of Birth: _____

Social Security #: _____ Phone #: _____

Address: _____ City, State, Zip: _____

Employer and Phone #: _____
Employer Address: _____

ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE
PLEASE COMPLETE THE INSURANCE SECTION – (EVEN IF COPIES HAVE BEEN MADE OF YOUR INSURANCE CARDS)

PRIMARY INSURANCE: Insurance Name: _____

Policy #_____ Group #:_____

Policy Holder Name: _____ Policy Holder Date of Birth_____

Policy Holder Social Security # _____

Relationship to Patient: Self Spouse Child Other

SECONDARY INSURANCE: Insurance Name:_____

Policy #_____ Group #:_____

Policy Holder Name: _____ Policy Holder Date of Birth_____

Policy Holder Social Security # _____

Relationship to Patient: Self Spouse Child Other

PLEASE COMPLETE THE BACK SIDE OF THIS FORM

FINANCIAL POLICY (please initial)

We strongly feel all patients deserve the very best medical care that we can provide. Everyone benefits with financial arrangements are agreed upon. We have prepared this material to acquaint you with our policy.

Our professional services are rendered to you, not the insurance company. Payment for treatment is your responsibility.

_____ SELF PAY PATIENTS: I have no medical insurance coverage I understand that I am responsible for payment of services rendered to myself of dependents at the time of service.

_____ ALL PATIENTS: I understand if I fail to pay amounts owed; the clinic has the right to secure an on outside collection agency and/or attorney to collect the unpaid debt and to report the unpaid debt to a credit -reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collection agency or attorney, including reasonable attorney's fees.

_____ INSURANCE AUTHORIZATION: I hereby authorize the release of any information necessary to process insurance claims and request payment of benefits to be made for services rendered to my dependents or myself.

_____ CO-PAYMENT, COINSURANCE, DEDUCTIBLE: I understand I am responsible *at the time of service* for paying any required co-payment, coinsurance and/or deductible.

MEDICARE PATIENTS ONLY: Medicare Number _____

_____ I authorize any holder of medical or other information about me to release to the Social Security and Health Care Finance Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 providers' penalties for withholding this information.) Regulations pertaining to Medicare assignment for benefits also apply.

MEDIGAP (MEDICARE SUPPLEMENT) ONLY: Policy Number _____

_____ I authorize any holder of medical or other information about me to be released to process this Medigap claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or to the party who accepts assignment.

ALL CHECKS ARE PROCESSED ELECTRONICALLY.

THERE WILL BE A $25.00 CHARGE ON ALL RETURNED CHECKS.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY OF THIS OFFICE AND AGREE TO ABIDE BY THE SAID POLICY.

_____ _____

Patient/Parent/Guardian **Date**

Please present both your insurance card and your driver's license so we may make a copy for our records.

Tooele Clinic Corporation