



****Please Print****

Patient Information				Today's Date: / / 2008	
Last Name:		First Name:		Middle Initial:	
Date of Birth: / /	Age	Sex	Marital Status	SS#	
Street Address (including City, State and Zip)				Post Office Box	
Telephone No.: Home ()		Work: ()		Cell ()	
Employer's Name (If applicable)				Employer's Telephone No.:	
Employer's Address including City, State and Zip:					
Primary Care Physician Name:				Speciality:(Internal Med, Family Practice, OB etc.)	
Primary Care Physician's Address including City, State and Zip:					
Parent or Responsible Party (if different from patient)					
Last Name:		First Name:		Middle Initial:	
Date of Birth: / /	Age	Sex	Marital Status:	SS#	
Street Address (including City, State and Zip)				Post Office Box	
Telephone No.: Home ()		Work: ()		Cell ()	
Employer's Name (If applicable)				Employer's Telephone No.:	
Employer's Address including City, State and Zip:					
Primary Insurance Information					
Name of Insured: (Last, First, Middle)					
Insured's Address, City, State and Zip (If. P.O. Box, please also list street address)					
Insured's Home Phone: ()			Insured's Work Phone: ()		
Insured's Date of Birth / /	Age	Sex	Marital Status:		
Insured's Employer's Name (If applicable)				Employer's Telephone No.:	
Employer Address (City, State and Zip)					
Name of Insurance					
Insurance Address for Medical Claims: (Street or Post Office Box, City, State and Zip Code)					
Policy No.:			Group No.		
Is prior authorization needed for a visit to a specialist? Yes _____ No _____					
If yes, Prior Authorization Reference/Tracking No.: _____					



****Please Print****

Secondary Insurance Information			
Name of Insured: (Last, First, Middle)			
Insured's Address, City, State and Zip (If. P.O. Box, please also list street address)			
Insured's Home Telephone No.: ()		Insured's Work Telephone No.: ()	
Insured's Date of Birth	Age	Sex	Marital Status:
Insured's Employer's Name (If applicable)		Employer's Telephone No.: ()	
Employer Address (City, State and Zip)			
Name of Insurance:			
Insurance Address for Medical Claims: (Street or Post Office Box, City, State and Zip Code)			
Policy No.:		Group No.:	
Is prior authorization needed for a visit to a specialist? Yes _____ No _____			
If yes, Prior Authorization Reference/Tracking No.: _____			

AUTHORIZATION TO RELEASE MEDICAL INFORMATION, ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY FOR CHARGES INCURRED

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process primary, secondary, and/or Medigap insurance claims, insurance applications, laboratory and/or pathology tests, and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature: _____ Date: / /

Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. Insurance coverage may be pre-verified before any exam, treatment, and/or hospitalization. As applicable, co-payment, co-insurance, and/or deductible may be collected at the time of treatment. We accept payment in the form of cash, check or credit card.

In the event of a returned check, your check will be sent immediately to Express Recovery Services, Inc. wherein a minimum \$20 return check fee will be assigned. Separately, if your account is turned over to our Collection Agency, a collection fee equal to 33.3% of the balance submitted for collection will be added to your account.

Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature: _____ Date: / /

Do we have your permission to:

- Leave a message on your answering machine at home? Yes No
- Leave a message at your place of employment? Yes No
- Discuss your medical condition with a member of your household? Yes No

If yes, whom: _____ Relationship to patient: _____

Patient or Responsible Party Signature: _____ Date: / /