

TYPE OF VISIT: (check one)

- On-job injury: (do not check "Insurance" if you are injured at work)
- Private Pay: I will be paying in full, today, at the time of services
- Insurance: I will present my insurance ID card at check-in for approval

PAYMENT METHOD: (check one)

- Payment made today will be paid by:
- Cash
 - Visa / MC / Discover

PATIENT NAME AND INFO:

Patient Last Name: _____ First: _____ M.I.: _____

Address: _____ APT _____ Home phone: _____

City: _____ State: _____ Zip: _____ Cell phone: _____

Patient SS: _____ Patient Date of Birth: _____ Work phone: _____

Gender: Male Female Do you want to have secure web access to your labs/test results? Yes No

Email: _____

How did you hear about us? Friend/Relative Internet Drive By Other Preferred Language: _____

Preferred Pharmacy: _____

Pharmacy Location: _____

ACCOUNT NAME: (Fill in this portion only if patient is a minor OR if patient is insured through a family member)

If Insurance: This is the insured Person (person whose employer offers the Insurance, often the person whose SS# is on the ID card.)

If Private Pay: If patient is a minor, then enter parent's or guardian's information here.

Account Last Name: _____ First: _____ M.I. _____

Account SS# _____ Account Date of Birth: _____ Phone number _____

Patient's Relation to Insured person: Child Spouse

Only Primary Insurance will be billed, please make arrangements with primary insurance to forward information to secondary insurance to avoid being billed for remaining amount. (Medicare with Medicaid secondary will usually do this automatically)

EMERGENCY CONTACTS: (friend/relative to contact, if patient has a medical emergency or it is essential to discuss health) ok to discuss health

Name: _____ Relationship: _____ Tel. # _____ yes no

Name: _____ Relationship: _____ Tel. # _____ yes no

Authorization for treatment, Payment/Insurance, Release of records, Third parties information, Other:

I consent to the administration and costs of medical and surgical procedures, labs, x-ray, and medication which doctors deem necessary. I authorize the release and transfer of records and information regarding my treatment or medical condition to other providers for treatment purposes, to my insurance carrier and any other payor for payment, to my employer if my treatment is related to employment, for other healthcare operations, and as otherwise set out in the **Notice of Privacy Practices**, which I received today. I also received a **Notice Concerning Complaints** which is a part this form. I hereby guarantee payment of all center and physician charges incurred by the the above named patient (except for an authorized and qualified work related expense). I understand that no guarantee or assurance has been made as to the results, which may be obtained. I give permission to leave messages regarding my care at the Home/Cell Contact # listed above. I understand that **I must pay in full today** for all services rendered, unless my insurance is **accepted and verified**. I also understand that if my insurance is accepted and verified, **I must pay all applicable insurance copays, coinsurances and deductibles in full today**.

Private Pay patients only: I understand that an insurance claim will not be filed on my behalf, even if I acquire health insurance. I also understand that I may not be able to file insurance claim, depending on the policies of insurance company.

Insurance patients only: I understand that send-out (non-instant) labs/tests will be billed separately by the lab company – we do not collect fees for these.

Referrals/Third parties information: I understand that: (1)This practice does not receive any direct or indirect compensation for any of the referrals; (2) Some third parties have displays/brochures in this office – these are for information only and this practice does not approve/disapprove/maintain these. Most of the displays/brochures are displayed without compensation, but for some, this office receives monetary compensation for the space used; (3) Temporary/part-time doctors are not employees or agents of Complete Med Care – they are independent contractors, not controlled by this office.

Labs and Outside Tests Information:

I understand that if any labs/tests are ordered by the doctor, **I will need to call or come to the office to get all of the results**. Unless I am notified earlier, I promise to call or come to the office within five business days after the tests/labs are performed. I understand that **no call does not mean normal results**.

Patient/Guarantor's Signature _____ Date _____