PATIENT INFORMATION (CONFIDENTIAL)

Name_____Date_____

Address_____City_____State_____Zip_____

E-mail_____Cell phone_____Home phone_____

SS#_____Birthdate_____Circle one: Single Married Other

Employer_____ Work phone_____

Emergency contact:_____ Phone_____

How/where did you learn about our practice?_____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

☐ Same as above ☐ Another patient in our office

If other than patient, Name_____Relationship_____

If different from above, Address_____City_____State_____Zip_____

E-mail_____Cell phone_____Home phone_____

SS#_____Birthdate_____Circle one: Single Married Other

Employer_____ Work phone_____

PLEASE SIGN AFTER YOU HAVE READ THE FOLLOWING:

● To cover our up-front expenses until we receive your insurance payment, we ask that you ***pay your* estimated *patient portion at the time of service*** (or full amount if you do not have insurance) unless other arrangements have been made. We cannot know every detail of your policy and insurance companies reserve the right to deny payment in certain circumstances, so ***we cannot be responsible if the estimate we give you is different from the actual amount*** you will owe. If you have any questions about your insurance coverage, please contact your insurance company. We submit claims to your insurance company as a courtesy only.

● ***You are ultimately responsible for any amounts not covered by insurance***. We accept cash, checks, major credit/debit cards and Care Credit. A service charge of 1.5% (18% APR) may be applied to account balances not paid within 60 days. In the event that your account must be sent to a collection agency for non-payment, a fee equal to 40% of your balance will be added to cover costs of collections. A $25 service fee will be assessed for all returned checks.

●We respectfully request ***48 hours' notice to change or cancel an appointment***. This allows us to make that time available to other patients that may have immediate needs. We reserve the right to charge a ***$40 broken appointment fee*** (amount subject to change without prior notice) to offset the cost of unused staff time.

●Our ***Privacy Practices*** are posted on our website and copies are available upon request in our office. Your signature below acknowledges that you understand that you have access to full information about our Privacy Practices, that we will issue a revised notice of Privacy Practices if we significantly change them, that ***you consent to our use of your health information only for purposes of treatment, payment and healthcare operations***, and that you may revoke this consent at any time by giving written notice.

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Patient's (or Legal Guardian's) Signature Print Patient Name Date