PATIENT INFORMATION			
PATIENT NAME:		**HOME PHONE:**	
PATIENT ADDRESS:		**WORK PHONE:**	
CITY / STATE / ZIP CODE:		**CELL PHONE:**	
D.O.B.:	**S.S.#:**	**MARITAL STATUS:**	SEX (circle one): **Male** **Female**
EMPLOYER:	**OCCUPATION:**	**EMAIL ADDRESS:**	
PRIMARY CARE PHYSICIAN:	**PHONE:**	**REFERRING PHYSICIAN:**	**PHONE:**
HOW WOULD YOU LIKE US TO CONTACT YOU FOR TEST RESULTS?: ☐ **EMAIL** ☐ **MAIL** ☐ **TELEPHONE**			

PATIENTS UNDER 18 YEARS NEED PARENT/GUARDANTOR INFORMATION

RESPONSIBLE PARTY: _____ **D.O.B:** ____/____/____ **PHONE:** _____

ADDRESS: _____ **WORK PHONE:** _____

EMERGENCY CONTACT

NAME: _____ **RELATIONSHIP:** _____

PHONE: _____ **CELL/WORK#:** _____

INSURANCE INFORMATION			
POLICY HOLDER:		**POLICY HOLDER:**	
D.O.B:		**D.O.B:**	
PRIMARY INSURANCE:		**SECONDARY INSURANCE:**	
RELATIONSHIP TO PATIENT:		**RELATIONSHIP TO PATIENT:**	
ID/GROUP#:	**COPAY:**	**ID/GROUP#:**	

FINANCIAL POLICY

As a service to our patients, we would like to outline our policy toward the payment of service:

1. Payment on your account is due within 30 days by your health insurance or the responsible party. Although insurancebillings are done as a courtesy for you, we hold you responsible for your account. Any outstanding balance not paid by insurance after 90 days is the patient's responsibility.
2. Patient's co-payment is due at the time of your office visit. If we are not billing your insurance company, a deposit of $130 is due at the time of service unless other arrangements have been made by the accounts receivable department.
3. Your signature allows us to contact references in case it becomes necessary to locate you.
4. Accounts that are 60 days old are considered delinquent. A finance charge of $3.00 per month or interest of 1.5% per month (whichever is greater) will be added to cover the cost of additional handling
5. A charge may incur for appointments that are not cancelled with 24 hour notice.

I UNDERSTAND THAT MY INSURANCE MAY REQUIRE A PRIMARY CARE PHYSICIAN REFERRAL AND/OR PRIOR AUTHORIZATION FROM THE INSURANCE COMPANY FOR SERVICES RENDERED, OR THAT MY INSURANCE COMPANY MAY NOT COVER SERVICES THEY FEEL ARE NOT "REASONABLE OR NECESSARY" OR COVERED UNDER MY PARTICULAR INSURANCE COVERAGE PLAN. THEREFORE, I UNDERSTAND THAT I WILL BE HELD FINANCIALLY RESPONSIBLE FOR ANY AND ALL CHARGES INCURRED (INCLUDING LAB FEES) AT THE TIME OF VISIT. I ALSO UNDERSTAND THAT IF THE INSURANCE INFORMATION IS NOT CORRECT AND/OR I DO NOT HAVE MY INSURANCE CARD AVAILABLE AT TIME OF SERVICE I WILL ALSO BE HELD FINANCIALLY RESPONSIBLE FOR ANY AND ALL CHARGES INCURRED. I HEREBY AUTHORIZE THE ABOVE DOCTORS TO FURNISH THE INSURED'S INSURANCE COMPANY ALL INFORMATION WHICH SAID INSURANCE COMPANY MAY REQUEST CONCERNING MY PRESENT CLAIM.

The Federal Trade Commission has released a new rule to protect against identity theft. Patients must present a legal form of ID with their insurance cards. This will be copied along with the insurance cards and saved in the patients chart.

RESPONSIBLE PARTY SIGNATURE **PATIENT SIGNATURE** **DATE**

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