

PATIENT INFORMATION UPDATE

Please verify that the following information is correct. If any of the information is not correct, please mark through and print the correct information.

Appt Date: _____ Account #: _____

Physician: _____ Location: _____

Name:		
Address:		City/State/Zip:
Primary Phone: {a 10 digit number where we can reach you; no extension}		
Date of Birth:	Age:	Sex:
Marital Status:		Employer:

NO INSURANCE

INSURANCE INFORMATION: No Change Update

Please present your insurance card(s) to the receptionist.

Primary Insurance:		Insured's Name:
Policy #:	Group#:	
Secondary Insurance:		Insured's Name:
Policy #:	Group #:	

PAYMENT OF SERVICES AND NOTICE REGARDING INSURANCE:

If you do not have active Medical Insurance, payment will be required in full at the time of your visit.

If you have active Medical Insurance under a Plan in which we do not participate, payment of 50% of the billed charges will be required at the time of your visit. Any remaining balance, after payments or adjustments, will be your responsibility.

If we are filing insurance for your visit, we must have complete information, and any required referral information, at the time of your visit. If you cannot provide us with this information, we will not be able to file your claim and payment in full will be required at the time of your visit.

If we are able to determine that services provided will be charged against your Plan Deductible, such as surgical or office procedures, that amount may be due at the time of your visit, in addition to Co-Pay or Co-Insurance.

Patient/Guardian Signature: _____ Date: _____