

Welcome to Doctor's Family Clinic & Immediate Care.

Please complete this form and return it to the front receptionist promptly.
If this is a work related injury, please see the front receptionist immediately.

DO YOU HAVE MEDICARE? (circle one) YES NO If yes, please see the receptionist.

Patient Information

Social Security #'s are necessary to verify insurance information & may prevent delays or nonpayment

Name: (First) _____ MI: _____ (Last): _____

Date of Birth ___/___/___ Sex: M F Social Security #: _____

Address: (Street) _____ Apt. #: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____ Cell Phone: _____

Employers Name: _____ Phone Number: _____

EMERGENCY CONTACT: _____

Phone #: _____ **Relationship:** _____

Person Financially Responsible for Payment

Name: (First) _____ MI: _____ (Last): _____

Date of Birth ___/___/___ Sex: M F Social Security #: _____

Address: (Street) _____ Apt. #: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____ Cell Phone: _____

Employers Name: _____ Phone Number: _____

Your relationship to the patient: _____

Insurance Information

Although we have a copy of your card, you must complete the following to insure proper insurance processing.
Please be clear which insurance is primary vs. secondary to prevent delay or nonpayment.

Primary

Insurance Co.'s Name _____ Policy Holder's Name: _____

Policy Holder's DOB: _____ Policy Holder's Phone #: _____

Policy Holder's Employer: _____ Ins. Effective Date: _____

Insurance Co. I.D.#: _____ Insurance Co. Group#: _____
(Social security number of policy holder required if there is no I.D. # listed on the insurance card)

Ins. Co. Claim Address: _____ Ins. Co. Phone #: _____

Secondary

Insurance Co.'s Name _____ Policy Holder's Name: _____

Policy Holder's DOB: _____ Policy Holder's Phone #: _____

Policy Holder's Employer: _____ Ins. Effective Date: _____

Ins. Co. I.D. #: _____ Insurance Co. Group #: _____
(Social security number of policy holder required if there is not I.D. # listed on the insurance card)

Ins. Co. Claim Address: _____ Ins. Co. Phone #: _____

We understand that medical insurance can sometimes be intimidating and confusing to the patient. Doctor's Family Clinic & Immediate Care is NOT participating with all insurance companies. Please confirm with the receptionist if you are not sure if we are contracted with yours. Our staff will do their best to help you understand the insurance process, and will be glad to answer any questions that you might have.

It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance company.

If your insurance carrier requires that you obtain a referral from your primary care physician, it is your responsibility to obtain a referral from your PCP. Verbal authorization from your PCP or the doctor on call may be required. If no referral is obtained the balances will become your responsibility.

Signature on File

I authorize this holder of medical and other information about me to release to the Centers for Medicare and Medicaid Services or its intermediaries, carriers, and agents (your insurance company), any information needed to determine the benefits for this or a related claim.

Also, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I have read and fully understand the above information, have asked questions about anything not clear to me, and am satisfied with the answers I have received. I understand I may revoke this consent at any time.

Signature: _____

Date: _____

Financial Agreement

I agree to pay for services rendered according to Doctor's Family Clinic and Immediate Care's rates and terms. I understand that I am responsible for charges not covered by my insurance or other agency, which may include a deductible and coinsurance. If insurance payment is not received after 30 days, the balance in full becomes my responsibility. If this account is referred to an agency or attorney for collections, I agree to pay attorney's fees and collection costs, whether or not a lawsuit is filled.

I understand that I am financially responsible for all charges. Patient payments are due at time of service. Accounts unpaid after 60 Days are assessed a re-billing charge in the amount of \$5.00 per month.

There is a \$30.00 service fee on all returned checks. NSF checks must be redeemed with certified funds (cashier's check, money order, certified check or cash).

If this account is sent to a collection agency because of delinquency, I understand that I will be responsible for any and all collection service fees.

Signature: _____

Date: _____