

RED BUD INTERNAL MEDICINE & PEDIATRICS

Please fill out all information

PATIENT NAME: _____ SS# _____
Last First M.I.

Address: _____
Street City State

Home Phone: () _____ Cell Phone: () _____
Zip Code

Employer: _____ Work Phone: () _____

Date of Birth: ____/____/____ **Sex:** M or F (circle one) **Marital Status:** S M D W

Spouse Name: _____ **Employer:** _____ **Phone:** _____

PARENT OR LEGAL GUARDIAN (IF PATIENT IS MINOR)

Fathers Name: _____

Address _____

Home Phone: _____ Work Phone: _____

Mothers Name: _____

Address _____

Phone: _____ Work Phone: _____

DOES PARENT/GUARDIAN HAVE LEGAL RIGHT TO MEDICAL REC.? Yes No
If any parent not listed above has legal right to medical information, please give information:

Name: _____ **DOB:** _____ **Phone:** _____

EMERGENCY CONTACT: (Other than Home or Work)

Name: _____ **Relationship:** _____

Address: _____ **Phone:** _____

INSURANCE INFORMATION:

Primary Insurance: _____ Is this insurance through an employer? YES NO
If Yes - **Employer Name:** _____ **Employer Phone:** _____

Policyholder: _____ **Date of Birth** ____/____/____ **SS#** _____
Relationship to Patient: Self ___ Spouse ___ Parent ___ Other ___

Secondary Insurance: _____ Is this insurance through an employer? YES NO
If Yes - **Employer Name:** _____ **Employer Phone:** _____

Policyholder: _____ **Date of Birth** ____/____/____ **SS#** _____
Relationship to Patient: Self ___ Spouse ___ Parent ___ Other ___

PLEASE COMPLETE ALL INFORMATION ON THE REVERSE SIDE

FINANCIAL POLICY

We strongly feel all patients deserve the very best medical care that we can provide. Everyone benefits when financial arrangements are agreed upon. We have prepared this material to acquaint you with our policy.

Our professional services are rendered to you, not the insurance company. Payment for treatment is your responsibility.

FINANCIAL AGREEMENTS

Initial

_____ I have no insurance coverage I understand that I am responsible for payment of services rendered to myself or dependents at the time of service.

_____ I understand if I fail to pay amounts owed; the clinic has the right to secure an outside collection agency and/or attorney to collect the unpaid debt and to report the unpaid debt to a credit-reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collection agency or attorney, including reasonable attorney's fees.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Initial

_____ I hereby authorize the release of any information necessary to process insurance claims and request payment of benefits to be made for services rendered to my dependents or myself.

_____ I understand I am responsible at the time of service for paying any required co-payment and deductible.

MEDICARE/MEDIGAP

For Medicare Patients Only

_____ Medicare Number

_____ I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Finance Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. 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 the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Medigap Authorization Statement

_____ Policy Number

_____ I authorize any holder of medical or other information about me to be released to process this Medigap claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or to the party who accepts assignment.

There will be a \$25.00 charge on all returned checks.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY OF THIS OFFICE AND AGREE TO ABIDE BY THE SAID POLICY.

Patient/Parent/Guardian

Date

Please present both your insurance card and your driver's license so we may make a copy for our records.

I will be paying by: _____ Check _____ Cash _____ MasterCard/Visa/Discover/American Express