2019 Policies & Information Forms

Patient information:

Today's Date: _____ **Email:** _____

Name: _____ **DOB:** _____

Mailing Address: _____ **Age:** _____

City, State, Zip: _____ **SSN:** _____

Phone: _____ **Marital Status: Married ( ) Single ( ) Divorced ( ) Other ( )**

In case of Emergency, Notify: _____ **Sex: Male ( ) Female ( )**

Phone: _____ **Referred by:** _____

Relationship to patient: _____ **Phone:** _____

Insurance Information

Primary Insurance: _____ **Secondary Insurance:** _____

ID Number: _____ **ID Number:** _____

Mailing Address: _____ **Mailing Address:** _____

City, State, Zip: _____ **City, State, Zip:** _____

Name/Policy Holder: _____ **Name/Policy Holder:** _____

SSN: _____ **SSN:** _____

DOB: _____ **DOB:** _____

Prescription card if separate RX Bin_____ **PCN**_____ **Group**_____

Employment Information

Employer: _____ **Telephone:** _____

Mailing Address: _____ **City, State, Zip:** _____

Responsible Party Information

Name: _____

Mailing Address: _____

City, State, Zip: _____

DOB: _____

SSN: _____

As the responsible party, I agree that all charges that are not directly paid by the insurance company will be my responsibility.

X _____
Responsible Party Signature

Phone: _____

Payment of Benefits

I authorize payment of benefits, as determined by the insurance company, directly to the physician's office. I understand that I still may be responsible for any amounts not paid by my insurance company.

Signature: _____ **Date:** _____

Medical Release Authorization

I authorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to release any information requested with regard to processing my claim. I certify that all information on this form is true and correct to the best of my knowledge. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

Signature: _____ **Date:** _____

Prescriptions and After hours

Any calls before and after office hours will be returned the next business day.

If it is a medical emergency or you are in crisis, please report to your nearest emergency room.

No prescriptions will be filled outside of office hours.
Medications will only be adjusted,
Added or changed during visits

All controlled substances require a random drug screen

Prescriptions for controlled substances cannot be replaced if lost or stolen

Missed Appointment Policy

Appointment Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled **24 hours** in advance. Our providers want to be available for your needs and the needs of all our patients. If you frequently reschedule or no show, it will result in consideration of closure to your chart. **If you miss a scheduled appointment you will be responsible to pay $90.00 fee.** This fee is **not covered by insurance** and is the patient's responsibility. This fee will need to be paid before we make your next appointment.

You can reschedule or cancel your appointment by phone call or text.

By signing this agreement, you understand the importance of scheduling an appointment upon leaving the office.

Patient/Guardian Signature:_____
Witness:_____
Date:_____

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