PATIENT INFORMATION

REFERRED BY DOCTOR _____

HOW DID YOU HEAR ABOUT US _____

PATIENT'S NAME _____
                      LAST   FIRST   MIDDLE

PHONE: _____

    ADDRESS: _____ CITY: _____ ZIP: _____

PERSON RESPONSIBLE FOR THIS BILL: _____

    ADDRESS: _____ PHONE: _____

PATIENT INFORMATION: SEX: _____ RACE: _____ MARITAL STATUS: _____

    DATE OF BIRTH: _____ AGE: _____ RETIRED: _____ DISABLED: _____

PATIENT SOCIAL SECURITY # : _____ /PARENT/RESPONSIBLE SOCIAL SECURITY # : _____

    SPOUSE: _____ SPOUSE'S EMPLOYER: _____

PATIENT OR PARENT'S EMPLOYER: _____ PHONE: _____

PERSON TO CONTACT NOT AT YOUR ADDRESS: _____ PHONE: _____

INSURANCE - ARE YOU P.M.D. YES _____ NO _____

INSURANCE COMPANY: _____

    ADDRESS: _____

    POLICY HOLDER'S NAME: _____ DOB _____

    POLICY # : _____ GROUP # : _____

PATIENT'S RELATIONSHIP TO INSURED: SELF ( )   SPOUSE ( )   CHILD ( )   OTHER ( ) _____

MEDICARE # : _____ MEDICAID # : _____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE BOOKKEEPER. IN CASE OF NONPAYMENT, THE PATIENT IS RESPONSIBLE FOR ALL REASONABLE COLLECTION FEES, ATTORNEY FEES, COURT COSTS, INTEREST AND ALL OTHER EXPENSES. **AGREEMENT TO PAY: I THE UNDERSIGNED, ACCEPT THE FEE CHARGED AS A LEGAL AND LAWFUL DEB AND AGREE TO PAY SAID FEE, INCLUDING ANY/ALL COLLECTION AGENCY FEES, (33.33%), ATTORNEY FEES AND/OR COURT COSTS, IF SUCH BE NECESSARY.**
INITIAL: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE DR. MARGARET JAKES, DR. HUGH FRAZER, JR., DR. HARRY LEE, OR DR. DAVID H. FRAZER III TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED, AND AGREE TO PAY 1.5% INTEREST PER MONTH ON ALL UNPAID BALANCES.

DATE: _____ SIGNATURE: _____

REVISED 9/10/15