

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH _____ AGE: _____

LOCAL ADDRESS: _____ PHONE: _____

If Different, please correct below:

(street) (city) (state) (zip) (phone)

NORTHERN OR OTHER ADDRESS: _____

_____ () _____

SS #:«PSSN» _____ MARITAL STATUS: _____ SEX: «PSex»

EMERGENCY CONTACT _____ PHONE: () _____

CELL PHONE # _____ EMAIL ADDRESS: _____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME: _____ POLICY _____

WHO IS SUBSCRIBER: _____ DOB _____

(If you are not the subscriber for your insurance this information is mandatory to file your claim)

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME _____ POLICY ID _____

WHO IS SUBSCRIBER _____ SS# _____ DOB _____

(If Medicare is your secondary you must sign a separate Lifetime Medicare Signature form)

Auto Insurance(if applicable)

Insurance Name _____ Policy Number _____

Date of Accident _____ Claim Number _____

If Attorney is involved Please list Attorney Name _____

Address/Phone number of Attorney _____

MINOR AUTHORIZATION

_____ is the parent/guardian of _____ and I hereby authorize any treatment deemed medically necessary by the attending physician.

Signature of Parent or Guardian

Date

Yes or No I authorize my minor child to be seen without me for future visits relating to today's 10/25/2011 problem. If the address of parent or guardian is not the address on reverse side please enter here.

_____ phone _____

*****PRIVACY POLICY*****

I understand that this office has a privacy policy, as required by law. I was offered a copy to read and/or take with me. I understand my records are kept private and confidential. I am signing that I have been notified of our privacy policy.

Signature of Patient

Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION/RECORDS

1. I authorize Drs Fifer, Heligman, Gomez, Markovich, Hood, Follweiler, Kleiman and their employees or agents, to release medical and other information about me to my insurance company or its agents.
2. I authorize Drs Fifer, Heligman, Gomez, Markovich, Hood, Follweiler and Kleiman to release any medical and other information to any health care provider or facility that the physicians deem appropriate.
3. I am aware that Drs Fifer, Heligman, Gomez, Markovich, Hood, Follweiler and Kleiman routinely provide office notes on each visit to the office of my primary care physician. I authorize the release of these office notes and any other information that the physicians deem appropriate.
4. I am aware that I must complete a *REQUEST TO OBTAIN MEDICAL RECORDS* form in order for Drs Fifer, Heligman, Gomez, Markovich, Hood, Follweiler and Kleiman to release information or medical records to parties not listed.
5. I understand that this release authorizes our office to discuss the medical care of the minor with his/her parent or guardian.
6. I authorize Drs Fifer, Heligman, Gomez, Markovich, Hood, Follweiler and Kleiman to release my records to me (the patient) for up to one year from this signed authorization. I understand that I may be charged for these records.

Patient Signature

Date

STATEMENT OF FINANCIAL RESPONSIBILITY

1. I assign payment of all insurance benefits under existing insurance policies to Drs Fifer, Heligman, Gomez, Markovich, Hood, Follweiler and Kleiman including funds payable to an attorney involved in the claim.
2. In the event that products and/or services are provided that are not covered by my plan(s) I will be responsible for payment for those products and/or services.
3. I understand that Drs Fifer, Heligman, Gomez, Markovich, Hood, Follweiler and Kleiman submit claims to my insurance company on my behalf. I understand that I am responsible to insure that claims are paid by my insurance company and that I am financially responsible for products and/or services provided.
4. I understand a portion of the payment is due at the time services are rendered.
5. I understand that Drs Fifer, Heligman, Gomez, Markovich, Hood, Follweiler and Kleiman participate in many managed care plans and that companies, and plans within companies, differ in deliveries of care. It is my responsibility to remain current on insurance benefits. It is also my responsibility to insure that authorizations are obtained. We will provide care within your insurance plan guidelines whenever possible.
6. I understand that policies stated above and agree to accept responsibility as described.

Patient Signature

Date

If this is a Workers Compensation Plan, this area must be completed.

The above Financial Responsibilities will be only if improper information was given for WC claim and you become responsible per WC Carrier.

Employer _____ Phone Number _____

Employer Contact _____ Date of Injury _____

If you have an attorney related to this claim, please indicate Attorney here

Attorney Name _____ Phone Number _____