

Pt. First Name: _____ Today's Date: _____

Pt. Last Name: _____

Pt. DOB: _____

Pt. Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Referred By: _____

Spouse Name: _____

Emergency Contact Name: _____

Emergency Contact Number: _____

Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Employer Phone: _____

Insured Relation: _____ Insured Date Of Birth: _____

Insured Name: _____

Insurance Company: _____

Insurance I.D #: _____

Insurance Group #: _____

Law Firm: _____

Lawyer Name: _____

Lawyer Address: _____

Law Firm Phone: _____

Date of Injury: _____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself — not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney(s) who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: __/__/____