ACCOUNT NUMBER____________ New Patient ☐ Insurance Change☐ Address Change☐

PATIENT INFORMATION

Name: ____ SS#:____________________
Last name First name MI
DOB: _____________ Age: _____ Sex: □ Male □ Female
Street Address: ____
City: ___________________ State: _____________ Zip Code: ___________________
Phone (Home): _________________ Cell: _____________ Work: _______________
E-mail address: _____________________________________

INSURANCE INFORMATION

Primary Insurance: _____________Cardholder: □ Self □ Spouse □ Other__________
Card holder name: ____
Card holder SS#: _________________________ Card holders DOB: _______________
Secondary Insurance: ___________Cardholder: □ Self □ Spouse □ Other_________
Card holder name: ____
Card holder SS#: _________________________ Card holder DOB: ________________

☐ **CHECK IF SELF PAY**

IF PATIENT IS MINOR

Person responsible for bill: ____________________________ Phone: _______________
Address (if different from above): ____
____

1. If we do not receive a response from your insurance company after 70 days the balance due will be transferred to you.
2. If your insurance does not cover office visits or you do not provide us with correct insurance information at any time, you will be responsible for payment at the time of the office visit.
3. Copayments must be paid at time of service. We accept cash, check or credit card.
4. Verify that Dr. Kubala, Dr. Cox and Dr. Brown are providers under your current plan.
5. You will be charged **$50.00** for a missed appointment if you do not cancel or reschedule your appointment prior to your scheduled time.

STATEMENT TO PERMIT PAYMENTS OF INSURANCE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENT:
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration or its intermediaries or carriers any information needed for this or a related insurance claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the organization furnishing the services or authorize such physician or organization to submit a claim to insurance for payment to me.
I request that payment under the medical insurance program be made to me, or to the Physician on any bills for services furnished me by the Physician during the next 12 months.
I hereby authorize the Physician to release any medical information pertaining to their services and to submit to my insurance company or its representative, and any and all information they may have regarding my or my dependant's condition when under observation or treatment by them, including history obtained, diagnosis and treatment. A photocopy of my signature may be used. I hereby assign the benefits payable under my insurance to the Physician. I agree to verify that all ancillary care and referring physicians are covered under my policy prior to services being rendered.

Legal Signature: ____Date: _____________