

**PATIENT INFORMATION**

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
STREET \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
CELL PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
BIRTH DATE \_\_\_\_\_ ( ) MARRIED ( ) SINGLE ( ) OTHER ( ) CHILD  
SPOUSES NAME \_\_\_\_\_  
REFERRED BY \_\_\_\_\_

**RESPONSIBLE PARTY**

SAME AS PATIENT ( )  
NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
STREET \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**INSURANCE INFORMATION**

(WE CAN PHOTOCOPIY YOUR INSURANCE CARD)

INSURANCE COMPANY \_\_\_\_\_ ( ) MEDICAL ( ) VISION  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
ID# \_\_\_\_\_ GROUP/PLAN \_\_\_\_\_

**I PLAN TO MAKE PAYMENT OF MY NON COVERED EXPENSES AS FOLLOWS:**

( ) CASH/CHECK ( ) CREDIT CARD

**AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT**

I authorize treatment for the above named person and agree to pay all fees and charges for such treatment. I agree to pay all charges shown on statements promptly upon presentment thereof, unless credit arrangements are agreed upon on writing. Charges shown on statements are agreed to be correct and reasonable unless protested within thirty days of billing date.

Our staff will help with completion of insurance forms as an accommodation and convenience to you without charge. IT IS THE PATIENTS RESPONSIBILITY TO KNOW YOUR CONTRACT BENEFITS, ASSURE COLLECTION OF INSURANCE PAYMENTS TO US, AND TO NEGOTIATE WITH YOUR INSURANCE COMPANY OVER ANY DISPUTED CLAIMS. It is agreed that payments will be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without assuming responsibility for the collection thereof.

All account balances sixty days or older will be subject to a finance charge of 1.5% per month (annual rate of 18%). A charge of \$25.00 will be assessed to all returned checks. A charge of \$25.00 will be assessed to any accounts turned over for collection or a 40% charge will be added to remaining balance which ever amount is greater. In the event legal action should become necessary to collect an unpaid balance due for services rendered I agree to pay all attorney's fee and costs.

\_\_\_\_\_  
PATIENT OR RESPONSIBLE PARTY SIGNATURE

\_\_\_\_\_  
DATE