

Life's Bounty Medical Care

Doctor: _____

Patient Information

Name: _____

Male () Female ()

Address: _____

D.O.B.: _____

City, State, Zip: _____

SS#: _____

Home Telephone #: _____

Referred by: _____

Work Telephone #: _____

E-mail Address: _____

Mobile Telephone #: _____

Emergency Contact Information

Name: _____

Phone: _____

Insurance Holders Information

Primary Insurance

Insurance Company: _____

I.D. #: _____

Name of Insured: _____

Group #: _____

M () F () Insurance Holders DOB: _____

Relationship to Patient: _____

Insurance Holders SS#: last 4 numbers ONLY! ___-___-___-___

Phone #: _____

Secondary Insurance (if any)

Insurance Company: _____

I.D. #: _____

Name of Insured: _____

Group #: _____

M () F () Insurance Holders DOB: _____

Relationship to Patient: _____

Insurance Holders SS#: last 4 numbers only! ___-___-___-___

Phone #: _____

If patient is a minor (under 18), please list the parent or guardian's name (s): _____

Parent or guardian's D.O.B.: _____

REGARDING INSURANCE: With proper identification, this office will bill your Insurance, Managed Care, HMO or PPO provider for our usual and customary charges as a courtesy to you. In the event we do not receive payment in full or our usual and customary charges from your insurance provider within 45 days of billing, the amount owed will be billed to you and payment will be expected within 30 days. All co-pay and deductible portions are due prior to treatment where we are participating provider for such plan.

INSURANCE CHANGES: It is the responsibility of the patient/guarantor(s) to provide this office with any future changes in insurance plans, referral and pre-certification forms (as required by your individual Insurance Plan) prior to treatment, and to make certain that we are listed as your primary care provider where necessary.

NON-PAYMENT: I understand that if my account is turned over to a collection attorney or a collection agency for non-payment I will be responsible for any additional fees as allowed by law.

I/We authorize release of any medical information and billing information to any third party in order to necessitate payment to this office.

I/We authorize any and direct any insurance Provider to pay all benefits payable to me/us directly to this office (a photo copy of this agreement may be used in lieu of original).

Signature: _____

Date: _____