

**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: \_\_\_\_\_