PATIENT INFORMATION

PATIENT: _____ _____ _____
Last Name First Name M.I.

Home Phone _____ Cell _____ Work_____

Birth Date___/____/____ Marital status: S M W D SEP (Circle) Social Security____/_____/_____

Mailing Address _____City_____ State_____ Zip _____

Email: _____

Emergency contact: _____ Phone: _____

Employer:_____

INSURANCE NAME_____I.D. # _____GROUP_____

INSURANCE POLICY HOLDER'S NAME: _____

Policy Holder's Employer_____ Business # _____

Policy Holder's Birth Date___/____/____ Last 4 Digit SS#_____ Relationship_____

SECONDARY INSURANCE

INSURANCE NAME_____ I.D. #_____GROUP_____

INSURANCE POLICY HOLDER'S NAME: _____

Policy Holder's Employer_____ Business #_____ Ext._____

Policy Holder's Birth Date_____ Last 4 Digit SS#_____ Relationship_____

Please read and sign below

Assignment of Insurance Benefits/Consent for Treatment/Acknowledgement

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on my behalf or dependent's. I further agree and acknowledge that my signature on this document authorizes my physician to submit all claims for benefits for services rendered without obtaining my signature on each and every claim and that these claims may be paid directly to her. Also, I hereby grant Dr. Brooks and her medical staff to perform such medical procedures as discussed with me as deemed necessary. If the above patient is a minor, I am granting permission for treatment and I am an authorized person to do so. I have also received a copy of the "Notice of Privacy Practice" upon request and if I have any questions, may discuss them with the staff. I also understand the financial policy to be:

1. Payment is due at the time of service and a **$5-**statement fee will be added to unpaid accounts. Returned checks will incur a **$25-** service fee. A **$25-** cancellation fee will apply to appointments cancelled ***less than*** 24hrs. in advance.
2. **Accounts past 45 days are patient's responsibility per state law.** Unless prior arrangements have been made with our office.
3. Accounts past 90 days will be referred to collections. A **$25-** collection fee will be added to accounts referred to collections and once with the agency, the patient must deal directly with the collection agency to clear the account.
4. **Please note your Credit card will be charged for outstanding balances**, and/or surgical deductibles, out of pocket expenses, and percentages deemed patient responsibility by their insurance company.
5. **By signing below, you acknowledge you have read and understand the above information.**

Signature: _____ Date: _____
Patient (or parent if minor)