Patients Information

Name: _____ SSN: _____
Last First MI
Marital Status: ____ Married ____ Single ____ Other Email Address: _____

Birthdate: _____ Sex: _____ Person Responsible for this account: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

For Minors Only:

Mother Name: _____ Phone Number: _____

Fathers Name: _____ Phone Number: _____

Emergency Contact

Name/Relationship: _____/_____ Phone Number_____

Insurance Coverage

Primary Insurance: _____ Secondary Insurance: _____
Subscriber Name (If Different):_____ Subscriber Name (If Different):_____
Subscriber Employer: _____ Subscriber Employer: _____
Birthdate: _____ Birthdate: _____

CONFIDENTIAL COMMUNICATION

I wish to be contacted in the following manner (check all that apply)

Home Telephone: _____
- ☐ Leave message with detailed information
- ☐ Leave message with call back number
- ☐ Leave detailed message with a family member

Cellular Telephone: _____
- ☐ Leave message with detailed information
- ☐ Leave message with call back number

Work Telephone: _____
- ☐ Leave message with detailed information
- ☐ Leave message with call back number

Whom may we leave a message with & discuss your health care?
_____
_____

Pharmacy: _____ City: _____

Please initial the following and sign at the bottom:

_____ **Financial Policy (full policy attached):** As a courtesy to our patients**,** All Seasons Family Heath Care will bill most U.S. health plans. Deductibles, co-pays and/or coinsurance will be collected in full at the time of service. The amount of payment due at the time of visit depends on your insurance plan. We will also collect on any balance due on your account. Signing below indicates that you have read and understand our full financial policy attached to this form.

_____ **Noncovered Services:** Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial. Since your agreement with your insurance carrier is a private one, we do not routinely research whether a service is covered. It is the patient's responsibility to find out if a service is covered prior to service.

Missed Appointments: In fairness to other patients and the doctor, we require at least 24 hours notice to cancel appointment. If you miss three appointments in a 12 month period, you may be dismissed from the practice. You will be charged a $25.00 fee for missed appointments.

Signature_____ **Date:** _____