CONFIDENTIAL

Date:_____
Dx Code:_____
(Ofc Use) _____

## PATIENT INFORMATION

**Last Name:**_____ **First:**_____

**Date of Birth:**_____ **Sex: M___F___**

**Home Address:**_____ **Home Ph: ( )**_____

**City:**_____ **Work Ph: ( )**_____

**Zip:**_____

**Employer Name:** _____

***Marital Status:*** *(please check one)*
*Married ___ Divorced ___*
*Single ___ Other _____*

## INSURANCE INFORMATION

**Primary Insurance:**_____ **InsuredName:**_____

**Address:** _____ **Insured DOB:** _____ **Employer:**_____

**City/State/Zip:** _____ **ID#:**_____

**Phone #:** _____ **Group #:** _____

**(we will need to copy your primary insurance card during your first visit)**

**Secondary Insurance:**_____ **InsuredName:**_____

**Address:** _____ **Insured's DOB:** _____ **Employer:** _____

**City/State/Zip:** _____ **ID # :** _____

**Phone # :** _____ **Group # :** _____

**I, the undersigned, certify that I (or my dependent)have insurance coverage with**_____ **insurance company (ies) and assign directly to Dr.**_____ **all insurance benefits, if any, otherwise payable by me for services rendered. I understand that I am financially responsible for all charges whether paid by the insurance or not. I hereby authorize the doctor/clinician to release all information necessary to secure the payment of benefit. I authorize the use of this signature on all insurance submissions.**

SIGNATURE OF RESPONSIBLE PARTY RELATIONSHIP DATE SIGNED

**Note: Please contact C.D. Billing Services for all billing/payment questions.**
**Phone # (888) 570-1020 Fax # (888) 570-1021.**

# PATIENT FINANCIAL AGREEMENT

**CONFIDENTIALITY:**

**I understand that my records are confidential and will not be released to outside individuals of agencies without written consent. However certain information may be released without my authorization under the following circumstances:**

1. **In the event of a medical emergency.**
2. **If there is evidence of child abuse, dependent or elder abuse.**
3. **When a hazard to the public requires disclosure.**
4. **When there is an indication that I will likely harm myself.**

**TELEPHONE CONSULTATIONS:**

**I understand that telephone consultation are not covered by Medicare and other health plans. Therefore, I understand that telephone contacts beyond appointment scheduling may result in a charge equivalent of $120.00 per hour for the duration of call.**

**CANCELLATIONS:**

**Appointments are regarded as a contract for the exclusive use of the doctors time. I understand that regular charges may be applied to missed appointments without 24 hour advance cancellation notice. I understand that my insurance carrier will not pay for my absence and I may be responsible for these charges.**

**Signature:** _____ **Date:** _____

**(I understand my financial and business agreements listed)**