PATIENT INFORMATION

PFPC

PATIENT'S LAST NAME	FIRST NAME	MI	SEX	BIRTHDATE	AGE
			Male Female Unknown	/ /	

STREET ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE

PATIENT'S Email ADDRESS	MOBILE PHONE

PATIENT OCCUPATION	HOW LONG EMPLOYED	PATIENT ID/DL	BUS. PHONE

PHARMACY NAME AND ADDRESS	CITY	STATE	ZIP CODE	PHARMACY PHONE

PARENT OR GUARDIAN

NAME	RELATIONSHIP TO PATIENT	PHONE

GUARDIAN ADDRESS	CITY	STATE	ZIP CODE

Insurance, Payment and Eligibility

Primary INS	PAYER (INSURANCE) NAME	PAYER PLAN		POLICY #
	NAME OF POLICY HOLDER	Relation to Insured	EFFECTIVE FROM	GROUP #
	ADDRESS OF PAYER (INSURANCE)			PAYER PHONE (FOR PROVIDERS)
Secondary INS	PAYER (INSURANCE) NAME	PAYER PLAN		POLICY #
	NAME OF POLICY HOLDER	Relation to Insured	EFFECTIVE FROM	GROUP #
	ADDRESS OF PAYER (INSURANCE)			PAYER PHONE (FOR PROVIDERS)

INSURANCE AUHTORIZATION AND ASSIGNMENT

NAME OF POLICYHOLDER:		POLICY #:	

I request that payment of authorized insurance company benefits be made either to me or on my behalf to Peachtree Family Psychiatry Clinic for all services furnished to me by that physician/supplier. I authorize Peachtree Family Psychiatry Clinic or its authorized agent to release services and medical information to Medicare, Insurance Company and or its agents needed to determine these benefits or the benefits to related services.

I understand my signature request payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, (secondary insurance box), my signature authorizes releasing of the information to the agency shown.

Signature:		Date:	

GUARDIAN - FINANCIAL RESPONSIBILITY

I understand that regardless of any insurance coverage, I am financially responsible for all charges generated for this patient. Office policy requires payment at the time of services. Should insurance benefit assignment be accepted any non-paid services will be paid by me within 30 days of notification. I understand that unpaid balances over 30 days past due may carry a late fee equivalent to 1.5% of that outstanding balance.

Print GUARDIAN name:	Signature:	Date