Date________________________

Advance Directives: ☐ YES ☐ NO
If yes, please, provide us a copy.

Patient Information

Patient Name (Last - First - Middle) Mr. Dr. Ms. Mrs.	Gender M F	Date of Birth	Social Security No.
Street Address	Home Phone No. ( )		Cell Phone No. ( )
City, State, Zip	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed		Occupation

In Case of Emergency, Notify	Emergency Contact's Phone No. ( )
Employer	Employer Phone No. ( )

Insurance Information

We cannot guarantee insurance coverage by your insurance carrier. The information below will assist us in determining if some of the expenses are reimbursable by your insurance carrier. **Please, give your insurance card to our receptionist to be copied.**

Primary Insurance Carrier	ID #	Group #	Social Security No.
Name of Insured	Relationship to Insured	Date of Birth	Gender M F
Street Address	Home Phone No. ( )	Work Phone No. ( )	
City, State, Zip	Employer	Occupation	

Secondary Insurance Carrier (if applicable)	ID #	Group #	Social Security No.
Name of Insured	Relationship to Insured	Date of Birth	Gender M F
Street Address	Home Phone No. ( )	Work Phone No. ( )	
City, State, Zip	Employer	Occupation	

Authorization and Release

Initial	Authorization and Release
	I certify the above information is true and correct to the best of my knowledge. I certify that I (or my dependent) have insurance coverage and assign directly to Seven Hills Medical Arts, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand and agree that I am ultimately responsible for payment and that at this time services rendered ***may not*** be covered by my insurance. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that if for any reason my account is delinquent and turned over to a collection agency, I am responsible for the collection agency fees (22% of amount owed) and/or any and all legal fees.
	I authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that billing is done by a third party and that I may contact them with questions regarding my account.
	HIPPA DISCLOSURE I acknowledge that I have been provided a Notice of Privacy Practices.

______________________________ Patient / Responsible Party Signature

____________________ Relationship

__________ Date