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)