PATIENT INFORMATION

PFPC

PATIENT'S LAST NAME	FIRST NAME	M.I	S.S.#	MARTAL STATUS		SEX	BIRTHDATE	AGE
				S	W	MALE		
				W	D	FEMALE	/ /	

STREET ADDRESS	CITY	STATE	ZIP CODE	BUS. PHONE

PATIENT'S EMPLOYER	OCCUPATION	HOW LONG EMPLOYED	BUS. PHONE

EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

SPOUSE/PARENT'S NAME (CIRECLE ONE)		S.S.#

SPOUSE'S EMPLOYER	OCCUPATION	HOW LONG EMPLOYED	BUS. PHONE

EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

GUARANTOR IF NOT ABOVE	NAME	RELATIONSHIP TO PATIENT	HOME. PHONE	BUS. PHONE

GUARNTOR ADDRESS	CITY	STATE	ZIP CODE

IF YOU HAVE TWO INSURNACES, INDICATE WHICH IS (P)RIMAY AND (S)ECONDARY - WE WILL NEED TO MAKE A COPY OF INSURANCE CARD(S)

P / S	BULE SHIELD(GIVE POLICY HOLDER'S NAME)	EFFECTIVE DATE	CERTIFICATE #	GROUP #	COVERAGE CODE

P / S	COMMERCIAL INSURANCE CO. NAME	EFFECTIVE DATE	POLICY #

P / S	COMMERCIAL INSURANCE CO. NAME	EFFECTIVE DATE	POLICY #

P / S	MEDICARE (PLEASE GIVE NUMBER)	P / S	RAILROAD RETIREMENT (PLEASE GIVE NUMBER)

P / S	MEDICAID	EFFECTIVE DATE	PROGRAM #	COUNTY #	CASE #	ACCOUNT #

WERE YOU INJURED ON THE JOB?	DATE OF INJURY	IDUSTRIAL CLAIM #

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: ____________________

GUARANTOR - 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 Guarantor name:____________________ Signature:____________________ Date:__________

REFERRAL SOURCE

We would greatly appreciate your taking a moment to help us identify our referral sources. Please indicate how you heard about us.

☐ Physician ☐ Friend ☐ Family (please give name):______________________________

☐ While pages (telephone book) ☐ Yellow Pages Other:______________________________