Coverdales -Hermann, LTD
Dr. Christopher Hermann, MD
Rene C. Curry, CRNP

Today's Date: _____/_____/_____

Patient Data:

Name: _____ _____
(Last) (First) (Middle) (Suffix or title)

Date of Birth: ___/____/_____ **S.S.N._____-_____-_____**

Street & Apt. #: _____

City: _____ **State: _____** **Zip Code: _____**

Phone: Home ( ) _____-_____ **Work: ( ) _____-_____** **Cell: ( ) _____-_____**

Contact Preference Cell Home Email _____

Gender: M F TG **Marital Status: S M D W Separated**

Race: Asian- African American- American Indian or Alaska Native- Caucasian-other

Ethnicity: Hispanic/Latino OR Non-Hispanic/Latino Preferred Language: English – Indian- Russian- Spanish- Other

HIPAA: I authorized the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

Name: _____ Relationship: _____Phone number: _____

Name: _____ Relationship: _____Phone Number: _____

Name: _____ Relationship: _____Phone Number: _____

I have received copies of the Coverdales – Hermann Patient Policies and Notice of Patient Privacy Practices

Signature: _____

Emergency Contact Person:

Name: _____

Relationship: _____

Phone: _____

Power Of Attorney Information:

Name: _____

Address: _____

Phone: _____

Retail Pharmacy Name: _____ Phone#: _____

Address: _____

Mail Order Pharmacy Name: _____ Phone #: _____

Insurance Subscriber is other then patient

Name: _____ _____
(Last) (First) (Middle) (Suffix or title)

Date of Birth: ___/____/_____ **S.S.N._____-_____-_____**

Street & Apt. #: _____

City: _____ State: _____ Zip Code: _____

Phone: Home ( ) _____-_____ Work: ( ) _____-_____ Cell: ( ) _____-_____

Relationship to Patient: *Self Spouse Dependent Other*

Please sign below. This is required for your benefits to be paid directly to the practice

REQUEST FOR PAYMENT AND ASSIGNMENT OF BENEFITS

I request payment and authorize any healthcare benefits that are otherwise payable to me by any insurance provider , benefit plan or other third party payer, under the terms of the insurance policy or benefit plan be paid directly to Coverdales -Hermann, LTD.
I understand that:
*I may be responsible for payment in full of any amount due that is not covered or paid for by any insurance policy or benefit plan.

RELEASE OF INFORMATION

I authorize Coverdales- Hermann, LTD:
*To give insurance provider, benefit plan, or other third party payer, or their agents, any medical or other information necessary to receive directly, on my behalf, any information related to my insurance policy or benefit plan (including, but not limited to, proof of my healthcare benefits).
*To file, on behalf of themselves or on my behalf, claims for benefits and/or appeals of any denied claims or authorization and to take action in my name against any insurance company, benefit plan or other third party payer, to receive any benefits that may be due or payable under the insurance policy or benefit plan.
*To give medical or other information to any healthcare practitioner providing healthcare services to me or receiving information from them.

STATEMENT OF ASSISTANCE

I agree:
*To assist Coverdales -Hermann, LTD. in collecting benefits that may be due or payable under my insurance policy or benefit plan for services, supplies and equipment provided.
*To provide any additional information needed to process the claim for payment.
*That a photocopy or other reproduction of this document shall be considered as valid as original.

_____ _____ _____
Signature of Patient/Signature of Person Authorized to Consent for Patient *Relationship to Patient* *Date*

I certify that the information on this form is correct and current:

Date: _____ Signature: _____