PATIENT INFORMATION

Patient Name:_____
Last *First* *M.I.*

Date of Birth: ____/____/____ **Age:** _____ **Sex:** □ Male □ Female **SSN:** _____

Mailing Address _____
City *State* *Zip*

Home Phone: ( )_____ Work Phone: ( )_____

Cell Phone: ( )_____ Employer: _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY *(if different from patient)*

Name: _____Date of Birth: ____/____/____
Last *First* *M.I.*

Address:_____
City *State* *Zip*

Home Phone: ( )_____ Work Phone: ( )_____

INSURANCE CARRIER INFORMATION: Do you have health insurance? ❑ YES ❑ NO

Primary: _____

Policyholder: _____ SSN: _____ Date of Birth: ____/____/____

Secondary: _____

Policyholder: _____ SSN: _____ Date of Birth: ____/____/____

PLEASE SIGN SO WE MAY HAVE YOUR INSURANCE AUTHORIZATION ON FILE

I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment.

Date: ____/____/____ Signature: _____

EMERGENCY CONTACT: _____ Phone ( )_____

Relationship to patient: _____

Do you give our office permission to discuss your medical information with family members?

❑ YES ❑ NO If yes, please provide their names and phone numbers below.

Name: _____ Relationship: _____

Phone # (day): (_____)_____ Phone # (evening): (_____)_____

May we leave personal medical information on your answering machine or cell phone?
❑ YES ❑ NO

REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name: _____

Referred by: _____ Primary Care Physician _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices).

Patient or Responsible Party Signature _____ Date ____/____/____

PAYMENT POLICY: We accept cash, checks, Visa, MasterCard, American Express & Discover

Insured patients: We will bill your insurance for covered services. You are required to pay your copay at the time of service and you will be responsible for paying your annual deductible and any copayment due after insurance is billed. You will receive two monthly statements after your insurance has processed your claim and have 30 days after the second statement to pay your balance before your account is forwarded to our collection agency. Payment for any non-covered, cosmetic services is required at the time of service.

Self Pay Patients: Patients who are not covered by insurance are responsible for the total bill at the time of the service. Payment is required at the time of service.

Minor Patients: It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion of the charges billed. Our office will file to insurance, however, payment is ultimately the responsibility of the adult presenting the child for treatment.

Payment Plans: We do not make payment plans for patients with outstanding balances on their accounts; for patients who wish to pay off their balances over many months we accept credit cards.

Your signature signifies that you understand that in the event any unpaid balance is placed for collections with any third party collection agency a fee of 50% of the unpaid balance will be added to the total amount due. This amount will be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, late fees and any other fees so stated elsewhere. The authorized fee of 50% and the additional costs and charges listed above represent the actual costs incurred by Dr. Korenberg to collect amounts owed under this agreement and a corresponding decrease in expected revenue resulting from this signer's failure to pay as specified in this agreement.

Your signature below signifies that you have read each item above and understand your responsibilities to this office.

Patient or Responsible Party Signature _____ Date ____/____/____
Staff Witness _____

Copy of Payment Policy given to signer