



PATIENT INFORMATION

Full Name (First/Middle/Last) _____

Home Address _____

Best Contact Phone Number _____ Alternate Phone Number _____

E-mail Address _____ Single _____ Separated _____ Married _____ Divorced _____

Date of Birth _____ Age _____ Gender _____

Preferred Pharmacy Name _____ Telephone # _____

Emergency Contact Information:

Name _____ Telephone # _____ Relation _____

Name _____ Telephone # _____ Relation _____

Do you have medical insurance coverage? YES () NO ()

Name of Insurance _____ I.D. Number _____

Insurance Plan Type: HMO PPO POS Other _____

ALL co-pays & deductibles must be paid at the time of service. This arrangement is part of our contract with your insurance company. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance does not pay your claim in 45 days, the balance will automatically be billed to you.

We do participate in most insurance plans, including Medicare. If you do not have medical insurance coverage or if you are not insured by a plan for which we are contracted providers, payment in full is expected at each visit. If you don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

No Show, Cancellation, & Fee Policy:

A "NO-SHOW" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as "no-show".

A late cancellation is considered when a patient fails to cancel their scheduled appointment with a 24-hour advance notice.

1st late cancellation or 1st missed appt a **\$50.00** fee will be billed to your account.

Translation – No Show with a scheduled translator will result in a **\$120.00** fee that will be billed to your account

Notary Fee – 15.00

SIGNATURE _____ **Date** _____