PATIENT INFORMATION FORM

PATIENTS FULL NAME ___________________________ DATE OF BIRTH ______________ SEX _______
OTHER 1) ________________________________ DATE OF BIRTH ______________ SEX _______
FAMILY 2) ________________________________ DATE OF BIRTH ______________ SEX _______
MEMBERS 3) ________________________________ DATE OF BIRTH ______________ SEX _______
4) ________________________________ DATE OF BIRTH ______________ SEX _______

HOME ADDRESS: ____

CITY: _______________________________STATE ___________________ ZIP _____________

EMAIL ADDRESS:_______________________________CELL PHONE: _______________________________

HOME PHONE: __________________________________WORK PHONE______________________________

MARITAL STATUS: M S D W REFERRED BY: ________________ PHYSICIAN: _____________

FINANCIAL RESPONSIBLE PARTY INFORMATION

FULL NAME: __________________________________ SOCIAL SECURTIY # _______________________

EMPLOYER: ___________________________________ OCCUPATION: ____________________________

HOME PHONE: ______________________________ WORK PHONE: _______________________________

INSURANCE: ____ POLICY #: __________________________

SECONDARY INSURANCE: ____________________________ POLICY #: __________________________

INSURANCE POLICY:
We will, in accordance with our provider agreements, bill and accept payment assignment for the following insurances: **Rocky Mountain Health Plans, Medicare, Medicaid, Vision Service Plan, CNIC, UFCW, VCPN, Beta Health, Rio Grand Hospital Association, Anthem blue Cross/Blue Shield, and Federal Blue Cross Blue Shield**. We will provide a statement for other insurances, which you may use to file and be reimbursed. All co-pays, deductibles, and additionals are the responsibility of the patient and are due the day of service. Having insurance does not relieve you of the financial responsibility for services provided.

FINANCIAL POLICY:
Payment for services is due at the time of service. If you need to make special arrangements, we offer the following terms: Sixty (60) days same as cash (pay ½ down at the time of service, the balance within 60 days).
After 60 days there will be a 1 ½ % per month (18% per year) interest charge on unpaid balances. All payments are due by the 10th of every month. There is a $10.00 fee on all returned checks.

I have read and I understand the insurance and financial policies of this office and I accept responsibility for payment. I will be paying for services by: CASH: _____ CHECK: _____ CREDIT CARD: _____

FINANCIAL RESPONSIBLE PARTY SIGNATURE: ____________________________ DATE: __________