

# PATIENT AUTHORIZATION & DEMOGRAPHICS



**TYPE OF VISIT:** (check one)

- Insurance:** I will present my insurance ID card at check-in for approval
- Private Pay:** I will be paying in full, today, at the time of service
- On-the-job injury**
- Auto Accident / Customer Injury / Third Party Property**

**PAYMENT METHOD:**

- Payment made today will be paid by:
- Cash
- Check (no temp or post dated)
- Visa/MC  Amex  Discover

**ACCOUNT NAME:** Very important to complete correctly! **IF using insurance, incorrect info will cause your claim to be rejected by insurance co.!**

**If Insurance:** This is the Insured Person (person whose employer offers the insurance, often the person whose ss# is on ID card)

**If Private Pay:** This is the patient, unless the patient is a minor, then the Account Name listed is the parent or guardian.

**If Work Related:** This is the patient, even though the company is responsible and is being billed.

Account Last name: \_\_\_\_\_ First: \_\_\_\_\_ M.I. \_\_\_\_\_  
(If insurance, this is name of **Insured** person/ person who carries the insurance)

Street address (include apt#): \_\_\_\_\_ Apt# \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Work phone: (\_\_\_\_) \_\_\_\_\_ Drivers license# \_\_\_\_\_ Account SS#: \_\_\_\_\_  
(If insurance, ss# of the **Insured** person)

**PATIENT NAME & INFO:** Must complete, even if same as above.

Patient Last name: \_\_\_\_\_ First: \_\_\_\_\_ M.I. \_\_\_\_\_

Patient SS# \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_ Patient Work/Cell#(\_\_\_\_) \_\_\_\_\_

Relation to Insured person:  Self  Child  Husband  Wife Gender:  Male  Female

**Complete only if using Insurance that is accepted:**

•Employer of Insured person: \_\_\_\_\_

•Insured Date of Birth: \_\_\_\_\_

•Do you have insurance with more than one health plan?  Yes  No

If yes: Name of other insurance co: \_\_\_\_\_ (Present both of your ID cards at front desk)

**Complete only if On-The-Job Injury:**

•Company Name: \_\_\_\_\_ •Name of supervisor who sent you: \_\_\_\_\_

•Company address: (street, city, state, zip): \_\_\_\_\_

•Company phone: (\_\_\_\_) \_\_\_\_\_ •If injury, **exact** date of injury: \_\_\_\_\_

Is your employment through a temporary service? Name of Temp Service \_\_\_\_\_

Is your employment through an independent contractor? Name of Contractor \_\_\_\_\_

**Authorization for treatment, Assignment of insurance benefits, Guaranty of payment, Release of records:**

I consent to the administration and costs of medical and surgical procedures, x-ray, and medication which doctors deem necessary. I authorize the release and transfer of records or information regarding my treatment or medical condition to other providers for treatment purposes, to my insurance carrier or any other payor for payment, to my employer if my treatment is related to employment purposes, for other healthcare operations, and as otherwise set out in the Notice of Privacy Practices, which I do hereby acknowledge receiving. I hereby guarantee payment of all center and physician charges incurred by the above named patient for this visit (except for an authorized and qualified work related expense). I understand that my attending physician and any other physicians who may consult or provide physician services (such as laboratory, radiology, pathology, emergency, and others) to me are not employed by and are not agents of CareNow, but are independently practicing professionals responsible for their own actions, and employed by Primary Health Physicians, P.A. I understand that no guarantee of assurance has been made as to the results, which may be obtained. I give permission to leave messages regarding my care at the home# listed above. I understand that I must **pay in full today** for all services rendered, unless, my insurance is accepted. I also understand that if my insurance is accepted that I **must pay** all applicable insurance copays, coinsurances, and deductibles in full today. If we are unable to verify your insurance at the time of service, you may be required to pay in full for all services.

**Emergency Contact / person not living at same residence**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ state \_\_\_\_\_ zip \_\_\_\_\_

**Patient/Guarantor's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_