

REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name: _____ Today's date __/__/__

Name of spouse: _____

Other family members who are patients: _____

Friends who are patients: _____

Primary Care Physician: _____

IN CASE OF EMERGENCY, CONTACT: _____ Phone: _____

PAYMENT POLICY:

Medicare: We are participating providers of the Medicare program. We will assignment on all claims. Patients are responsible for meeting their annual deductible and paying the 20% co-payment. We do file with secondary supplemental carriers, however, in the event that the secondary does not pay within 60 days, the patient will be billed.

Note: If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise if we are participating providers.

PPO and Medicare Patients: You are responsible for paying your annual deductible, copayment and charges for any non-covered, cosmetic services.

Patient or Responsible Party Signature: _____

MEDICARE PATIENTS ONLY:

This office is required to keep your signature on file authorize us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical of other information about me to release to the Social Security Administration and Health Care Financing Administration of its intermediaries of carrier any information needed for this or a related Medicare claim I permit a copy of this authorization to be used in place of the original, and request of medical insurance benefits either to myself of the party who accepts assignments. Regulations pertaining to Medicare assignment of benefits apply.

SIGNATURE AS IT APPEARS ON MEDICARE CARD: _____

If you have a supplemental policy and it is a **MEDIGAP** policy to which you Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits of the benefits payable for related services.

SIGNATURE AS IT APPEARS ON MEDIGAP CARD: _____