Patient's Name____________________________________ MR#___________________

Name of Policy Holder and Address:	Policy Holder's File # (For office use only)
Patient's Name:	Policy Holder's Date of Birth
Policy Holder's Place of Employment	(Circle one) For Policy Holder Male Female

I, ______________________________ fully understand and agree that I am solely responsible for updating my address, phone number and insurance information when there is any change. This office files insurance as a courtesy and I understand that I am solely responsible for my bill. I understand that if my bill has not been paid by my insurance company for any reason within three months of the date services were rendered to me, I will be responsible for the bill. Should my insurance company need any information regarding my bill, it is my responsibility to call them to update my file. I hereby authorize this office to release any information needed to obtain payment for my bill. I understand that my deductible and/or coinsurance are due at the time of my visit. I understand that my co-payment is due before services are rendered.

Should the doctor refer me to a specialist I understand that it is my responsibility to make sure that the doctor I am referred to is a participating provider with my insurance plan.

I understand that there will be at least a $10.00 charge for any form or letter that this office must provide or fill out for me. I understand that if my child is a minor, he/she must be accompanied by a guardian or an adult with written consent from the parent.

____ __________________

Patient or responsible party signature Date

If responsible party give relationship ____________________________________