The Doctors' Clinic

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ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

PATIENT INFORMATION Today's Date: ___/____/____

Patient Name: _____/_____/_____
Last First MI

Home Phone:(_____)_____ Cell Phone:(_____)_____

Mailing Address: _____
Street City State Zip

Email Address: _____ ☐ Check here to OPT OUT of Patient Portal

DOB:_____/____/_____ Age: ____ M F SS# _____- ___- _____ M S D W Other

Ethnicity: Hispanic/Latino Yes No

Race: Asian White Black American Indian/Alaska Native Undetermined
Native Hawaiian/Pacific Islander Multi-racial

Spouse's Name: _____ Spouse's Employer:_____

Person to Notify in an Emergency: _____ Phone:(_____) _____

Is illness/injury work related? Y N Date of Injury: _____ Claim #_____
Is illness/Injury the result of a MVA? Y N Date of Inury: _____ Claim #_____

INSURANCE INFORMATION

Primary Insurance:_____ Subscriber#:_____ Group #_____
Subscriber's Name: _____ SS#_____ DOB:____/____/_____
Address: _____ Phone: (___)_____
City State Zip
Employer Name:_____
Address City State Zip
Employer Phone:(____)_____

Secondary Insurance: _____ Subscriber#_____ Group #_____
Subscriber's Name: _____ SS#_____ DOB:____/____/_____
Employer Name:_____
Address City State Zip

OFFICE PAYMENT POLICY:
It is our policy to require payment of all office charges at the time they are given. All accounts are expected to be paid in full within 90 days, unless other arrangements have been made. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, including but not limited to reasonable attorney fees.

****Name of person accepting financial responsibility: _____
****Signature: _____

THE DOCTORS' CLINIC APPRECIATES THE OPPORTUNITY OF SERVING YOU. WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE.

CONSENT FOR TREATMENT AND ACKNOWLEDGEMENT OF RECIEPT OF NOTICE

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INSURANCE POLICY:

Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you, we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment, and any other pertinent information. You are responsible for all deductibles and charges not covered by insurance. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize The Doctors' Clinic to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostics, insurance, legal, and at times when the doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without further authorization signed by me for the release of the information.

ASSIGNMENT OF BENEFITS:

I hereby assign all benefits for services by The Doctors' Clinic and include major medical benefits to which I am entitled including Medicare, private insurance, and any other heath plan and I ask that The Doctors' Clinic furnish all requested medical information of the person or entity named above. I understand that my records may contain information regarding the diagnosis and treatment of HIV(Aids virus), or other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. This request is a free and voluntary act by me. (Statement required by law.)

The assignment will remain in effect until revoked in writing. A photocopy of this assignment is to be considered as an original document. I hereby authorize said assignee to release all information necessary to secure the payment. I understand that I am financially responsible to the provider for charges not covered by my benefit plan.

PRACTICE APPOINTMENT POLICY

The Clinic requires that appointments be cancelled 24 hours in advance. In the event that a patient fails to cancel or no shows three appointments without giving a 24 hour notice of cancellation, the patient can be discharged from the practice.

Printed Name: _____Signature: _____DOB:____/___/___

Patient Name if different than above: _____ Relationship: _____

Employee Initials: _____ Date: ____/_____/_____

I_____, give The Doctors' Clinic the right to release my health information to the following recipients.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____