Your Physician
is an
Independent Practitioner

Fahey Medical Center

Account #: ____________________

Doctor: ____________________

PATIENT INFORMATION

PLEASE PRINT CLEARLY

Name ____
LAST FIRST INITIAL

Responsible Party ______________________________ Relationship ____________________

Address ____
STREET CITY STATE ZIP

SSN ______-_____-______ Sex: M F Date of Birth ______________ Age __________ Marital Status: M - S - D - W

Employer ______________________________ Occupation ______________________________

Employer's Address ____
STREET CITY STATE ZIP

Home Phone ( ) ____________________ Business Phone ( ) ____________________ Extension: __________

STUDENT INFORMATION

Patient 18 or Older ❐ Part Time ❐ Full Time ❐ School Attending ______________________________

If Patient is Under 18 Responsible Party ______________________________

OTHER INFORMATION

In Case of
Emergency Contact ____________________ Relationship ____________________ Phone ( ) __________

Referred to this Physician by ______________________________

Work Related Injury? Yes ❐ No ❐ Employers Approval for Treatment ❐ Date of Injury ______________

Contact Name at Employer ____________________ Phone Number( ) __________ Extension __________

Patient Information (PI) Sheet Verified ____________________ Date: ______________ Form No. 200

If your Insurance is HMO – You <u>Must</u> Have a Referral to see your Specialist.

RESPONSIBILITY STATEMENT

Your insurance is a method for you to receive reimbursement for fees you have paid to the physician for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not with our office. It is your responsibility to pay the deductible, co-insurance, and any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill.

Insurance Type: Medicare ☐ HMO ☐ PPO ☐ Medicaid ☐ POS ☐ EPO ☐ Other ☐

Primary Company ______________________ Address ______________________ Effective Date __________

Policy Number ______________________ Group # ______________________ Phone __________

Subscriber ______________________ Relationship to Subscriber ______________________

D.O.B. ______________________ S.S.N. ______-______-______

Secondary Company ______________________ Address ______________________

Policy Number ______________________ Group Number ______________________ Phone __________

Subscriber ______________________ Relationship to Subscriber ______________________

List all Family Members on This Insurance: 1)______________________ 2)______________________

3)______________________ 4)______________________ 5)______________________

YOUR INSURANCE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.

The Non-Medicare Patient

I authorize the release of all medical information necessary to process this claim and that is pertinent to any medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, to *Fahey Medical Center*. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

The Medicare Patient

I request that payment of authorized Medicare benefits be made to me on my behalf to *Fahey Medical Center* for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Patient X ______________________ Responsible Party ______________________

Witness ______________________ Date ______________________