

PATIENT INFORMATION

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Allergies: \_\_\_\_\_

PERSON RESPONSIBLE FOR THIS ACCOUNT:

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security Number \_\_\_\_\_ Birthdate: \_\_\_\_\_ Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employers's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

INSURANCE INFORMATION:

Insurance Company: \_\_\_\_\_ ID #: \_\_\_\_\_

2<sup>nd</sup> Insurance Company: \_\_\_\_\_ ID #: \_\_\_\_\_

NEAREST RELATIVE AND EMERGENCY CONTACT:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

I understand and agree that:

1. Professional Fees are due and payable at the time such services are rendered.
2. ASSIGNMENT OF INSURANCE BENEFITS: In the event the undersigned is entitled to hospital-clinic benefits for any type whatsoever arising out of any policy of insurance insuring the patient or any other party liable to patient, said benefits are hereby assigned and directed to hospital clinic.
3. FINANCIAL AGREEMENT: The undersigned agrees, whether he signs as agent or as patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the hospital clinic in full at discharge. Should account become delinquent and subject to collection action, the undersigned shall pay reasonable attorney's fees, court costs, and collection expense up to 50% of the principle owing. All accounts bear interest of 1.5% per month, 18% per annum.
4. Medical information may be furnished to my insurance carrier at their request.

SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_