

CHART #: _____

PROVIDER: _____

PATIENT INFORMATION

PATIENT NAME:

LAST

FIRST

MIDDLE

ADDRESS: _____

ZIP CODE: _____

CITY: _____

STATE: _____

HOME PHONE #: (____) _____ - _____

CELL PHONE #: (____) _____ - _____

WORK PHONE #: (____) _____

DATE OF BIRTH: ____/____/____ SOCIAL SECURITY NUMBER: ____ - ____ - ____

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER

SEX: (circle one) FEMALE MALE

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: (circle one)

SELF

SPOUSE

CHILD

OTHER

PRIMARY CARE PHYSICIAN: _____

REFERRED BY: _____

PATIENT'S EMPLOYER INFORMATION:

COMPANY: _____

CITY: _____

PHONE #: _____

ACCIDENT INFORMATION: DATE OF ACCIDENT: _____ WORK RELATED? _____ AUTO: _____

OTHER: _____

RESPONSIBLE (OR INSURED) PARTY INFORMATION

RESP. PARTY NAME:

LAST

FIRST

MIDDLE

ADDRESS: _____

DATE OF BIRTH: ____/____/____ SEX: (circle one) FEMALE MALE

HOME PHONE #: (____) _____ - _____ WORK PHONE #: (____) _____ - _____

SOCIAL SECURITY NUMBER: ____ - ____ - ____

CELL PHONE #: (____) _____ - _____

RESPONSIBLE PARTY'S EMPLOYER INFORMATION:

COMPANY: _____

CITY: _____ PHONE #: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

ADDRESS: _____

PHONE: _____

CONTRACT (ID#) NUMBER: _____ SUBSCRIBER'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP NUMBER: _____

COPAYMENT AMOUNT: \$ _____ INSURED'S DATE OF BIRTH: ____/____/____

SECONDARY INSURANCE

COMPANY: _____

ADDRESS: _____

PHONE: _____

CONTRACT (ID#) NUMBER: _____

SUBSCRIBER'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ **GROUP NUMBER:** _____

COPAYMENT AMOUNT: \$ _____

INSURED'S DATE OF BIRTH: _____/_____/_____

WE APPRECIATE THE OPPORTUNITY OF SERVING YOU.

WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE.

OFFICE POLICY ON PAYMENT:

It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. All accounts over 60 days will be charged an interest rate of 1 1/2 percent per month (18% per annum) or a \$2.00 minimum. 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, which costs will not exceed 20% of said unpaid balance, including a reasonable attorneys fee.

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 Doctor 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: diagnostic, 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 a further authorization signed by me for release of the information.

I have read the above and accept financial responsibility in full for this account. I have been offered a copy of Dr. Gallagher's Notice of Privacy Practices.

SIGNED: _____

DATE: _____ Patient, Parent, or Guardian

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME: _____

PHONE NUMBER: _____ RELATIONSHIP: _____

ADDRESS: _____
