

****Present your Insurance Card and Drivers License to the receptionist with this completed form.**

PATIENT INFORMATION

Name _____
Last Name First Name MI

Address _____

City _____ State _____ Zip _____ Gender M F

Patient Employed by _____ Home Phone _____ Business Phone _____

Age _____ Birthdate _____ Soc.Sec. # _____

Marital Status: Single Married Partners Widow Separated Divorced

Spouse / Partners Name: _____ Do you give them permission to have access to your medical information without further written permission Yes No

If Patient is Minor: Mom's Name _____ Dad's Name _____

Mom's Phone # _____ Dad's Phone # _____

PRIMARY INSURANCE

Policyholder: _____
Last Name First Name MI

Insurance Company _____

ID/ Subscriber # _____ Group # _____

Gender: M F Date of birth: _____ Soc. Sec # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Policyholder Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip _____ Soc. Sec # _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____

ID/ Subscriber # _____ Group # _____

IMPORTANT INFORMATION

Emergency Contact _____ Phone # _____ Work # _____

Do you give us permission to discuss medical information with your Emergency Contact WITHOUT future written permission (YES / NO)

If you are new to our practice:

Previous Physician Name: _____ Phone # _____ City/State _____

How did you hear about us? _____

Assignment of Benefits and Permission to Treat

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered, or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I hereby authorize my insurance carrier(s) to pay and hereby assign directly to Dr. Jeffrey Hawtof and/or Dr. Matthew Tulloch and/or Longneck Family Practice P.A. all benefits, if any, otherwise payable to me for any and all of his/their services. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Dr. Jeffrey Hawtof and/or Dr. Matthew Tulloch and/or Longneck Family Practice P.A. will be credited to my account, in accordance with the above said assignment.

(Signature of Responsible Party) (Date)

Permission is hereby granted for physicians, residents, employees, or agents of Longneck Family Practice P.A. to render such medical and surgical treatment as is deemed necessary.

(Signature of Responsible Party) (Date)

In consideration of the services rendered to the patient, the undersigned agrees to accept full financial responsibility for the patient's account in accordance with the regular rates and terms of the facility. Should the account be referred for collection procedures, the undersigned shall pay reasonable attorney's fees and collection expenses.

(Signature of Responsible Party) (Date)

LONGNECK FAMILY PRACTICE
Financial Policy

PATIENT'S NAME: _____ **DATE:** _____

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service. We accept cash, check, Visa and MasterCard.
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company.
3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill these Plans for you. You are required to pay your copay BEFORE you are seen and any deductible or co-insurance at the time you check out.
4. If you are insured by a plan that we do NOT participate with you must pay for your charges at check out. We will provide you with a statement that you can submit directly to your insurance carrier and they will send any reimbursement directly to you.
5. Not all insurance plans cover all services i.e. complete physical exams, some lab work, etc. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
6. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.
7. If you miss your appointment without giving 24 hours notice and we are unable to fill your time slot or you write us a bad check you will be billed a fee that must be paid BEFORE you can be seen again. This charge cannot be submitted to your insurance company-- It is YOUR responsibility.
8. If you have and special circumstances, please contact our Office Manager.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of patient or responsible party, if minor