SCANLON & JOSEPHS, M.D., P.A.

DATE _____

PATIENT INFORMATION

LAST NAME _____ FIRST_____ MIDDLE _____
ADDRESS_____
CITY_____STATE_____ ZIP _____
PHONES/HOME _____WORK _____CELL _____
SEX _____ DATE OF BIRTH_____AGE_____
REFERRING DOCTOR _____ PRIMARY DOCTOR_____
ADDRESS_____ADDRESS_____
CITY, STATE, ZIP _____ CITY, STATE, ZIP _____
PHONE _____ PHONE _____

IN CASE OF EMERGENCY

NOTIFY_____RELATIONSHIP_____ PHONE _____

RESPONSIBLE PARTY INFORMATION

PERSON RESPONSIBLE FOR BILL _____ PHONE _____
ADDRESS_____
SOCIAL SECURITY #_____ EMPLOYER _____

INSURANCE INFORMATION

PRIMARY INSURANCE (attach copy of insurance card)
PLAN NAME _____ POLICY #_____ GROUP #_____
CLAIMS ADDRESS _____ PHONE _____
POLICYHOLDER_____ POLICYHOLDER'S DATE OF BIRTH _____
PATIENT'S RELATIONSHIP TO POLICYHOLDER _____

SECONDARY INSURANCE (attach copy of insurance card)
PLAN NAME _____POLICY #_____ GROUP #_____
CLAIMS ADDRESS _____ PHONE _____
POLICYHOLDER_____ POLICYHOLDER'S DATE OF BIRTH _____
PATIENT'S RELATIONSHIP TO POLICYHOLDER _____

PATIENT AUTHORIZATION

I hereby authorize Dr. Shelby Josephs to apply for benefits on my behalf for covered services rendered and I request payment from my insurance carrier to be made directly to Dr. Josephs.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either my insurance carrier or by me at any time in writing.

_____ _____

Date **Signature of Subscriber**

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on this account. If Medicare or other insurance company denies payment, I agree to be personally responsible for payment of the balance due.

_____

Signature of Responsible Party

ACKNOWLEDGEMENT

I, _____ (Patient or Parent of Patient) acknowledge that I have been given the opportunity to review Scanlon and Josephs, M.D., P.A. (the Practice's) Notice Regarding Privacy of Personal Health Information. I have been offered a printed copy of the Notice.

_____ _____

Signature of Patient /Parent **Print Name of Patient (if signed by parent)**

_____

Date