SPRUCE STREET INTERNAL MEDICINE, A PROFESSIONAL LLC

PATIENT INFORMATION Date:_____

NAME:_____ DATE OF BIRTH:___/___/___ SEX: M F O

Home Address:_____ City:_____ State:_____ Zip_____

Occupation _____ Employed by _____

Language Preference, if other than English:_____ Do you need a translator? YES NO

Relationship status: Single Married Same sex partner Other _____

_____ _____ _____
Home Phone Cell Phone Work Phone

May we leave messages for you about any test results at: HOME_____ CELL_____ WORK_____ EMAIL_____

Email address _____ (please print clearly)
(E-mail is **not** secure – others may have access to your information on the internet once it leaves our office)

Is there someone you authorize us to speak with about your care at Spruce Street Internal Medicine? Yes No

Name _____ Relationship _____ Phone number _____

SPOUSE OR PARENT

Name:_____ Home Phone:_____

Employed by:_____ Work Phone:_____

IN CASE OF EMERGENCY, PLEASE NOTIFY:_____

Relationship:_____ Phone:_____

Referred to our office by:_____

INSURANCE INFORMATION

POLICY HOLDER/SUBSCRIBER:_____ Date of Birth (HIPPA):_____

Name of the INSURANCE COMPANY:_____

ID or POLICY NUMBER: _____ Group Number:_____

Insurance is through what employment or association:_____

The above insurance covers: DIAGNOSTIC SCREENING/PREVENTATIVE BOTH TYPES OF COVERAGE _____ **Initials**

I authorize and request payment of medical benefits from the above insurance company to my physician for services provided.

I certify that I have provided a copy of my current medical insurance card and that, to the best of my knowledge, this insurance is in effect as of this date.

I understand that if this insurance information is later found to be incorrect, I will be responsible for prompt payment of today's charges and that I will be refunded any balance due to me once my correct insurance settles the claim for this visit. Initials_____

I have read and understand the Agreement for Payment of Services provided by Spruce Street Internal Medicine, LLC

SIGNED:_____ **DATE: _____**

Patient Name: _____

Date of Birth: _____

AGREEMENT FOR PAYMENT OF SERVICES

We believe that prompt payment for our services is a part of the contract that exists between doctor and patient. We will provide you and your family with quality medical services, including after hours coverage, 24 hours a day, 7 days a week, and you agree to pay us promptly for our services.

I understand that I am responsible for all charges for services provided for me or my family, regardless of insurance coverage, and that payment is due at the time services are rendered unless my physician has a contract with my insurance company to bill the insurance company first. I agree to pay any co-payments or deductible amounts for which I am responsible under by my insurance policy at the time of service; if I must be billed for co-payments, then I agree to pay a $5.00 billing fee in addition to my co-payment. I agree to pay for any services that I have received which are subsequently determined to be "not covered" by my insurance; if my insurance has a deductible or a co-insurance, I understand that I may be asked for a credit card at the time of service to which such fees may be charged.

All bills for services are due upon receipt, and any balance that remains unpaid for 30 days or longer will be charged a $35 late fee. If my account is referred to a collection agency or attorney, I understand that I will be liable for the collection fees, attorney's fees and any court costs, in addition to my outstanding balance. For services provided to me, or my family, while a patient in the hospital, I request that payment under my insurance be made directly to the doctor who provided the service. I authorize the release of medical information necessary to process my claim, if such information is requested by my insurance company**.**

INITIALS_____