

Patient's Full Name: _____ Date of Birth: _____

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell/Pager: _____

Employer's Name: _____ Your Occupation: _____

Employer's Address: _____ City/St _____ Zip _____ Your Social Security No: _____ - _____ - _____

Sex: Male Female Age: _____ Marital Status (current) Single Married Widowed Divorced Separated

Email: _____ If this is a secure email address, may we use it to contact you with lab results or other confidential info? Yes No

Emergency contact: Name: _____ Phone No: _____ Relationship to patient: _____

GUARANTOR/POLICY HOLDER *this information is required in order for us to file insurance for you. THANKS!*

Name of Policy Holder: _____ Social Security No: _____ - _____ - _____

Guarantor's Address: _____ Street _____ City _____ State _____ Zip _____

Guarantor's Date of Birth: _____ Guarantor's Phone No: Cell: _____ Wk: _____

Guarantor/Policy Holder's Employer's Name: _____ Occupation: _____

Guarantor/Policy Holder's Employers Address: _____

INSURANCE INFORMATION *NOTE: Complete the information in this box only if you do not have your insurance card with you today!*

Name of Insurance Co: _____

Insurance Address: _____ City/State: _____ Zip: _____

Insurance Phone No: _____ Policy #: _____ Group #: _____

We must have your insurance card to copy for our records. We would also like a copy of your drivers license for identifications purposes and also so that we may have a picture of you in your chart. You may be responsible for full payment today if unable to provide the insurance card.

YOUR PERMISSION IS REQUIRED TO RELEASE YOUR MEDICAL INFORMATION (lab results, appointment information, etc.) TO ANOTHER PERSON
If you are 18 yrs of age or older, we must have your written permission to release any medical information to ANY person other than yourself. Please read and sign below if you would like to give consent for us to speak to someone else (spouse, significant other, family member, etc.) concerning you. I, authorize West Lake Family Practice to discuss anything pertaining to my medical care to any of the following persons; (Please check the box and WRITE THEIR NAME in the blank space)

Spouse _____ Name Mother _____ Name Other _____ Name (relationship to you) _____

This information may be disclosed by fax, by mail, or by oral communication. I understand that my records are protected and cannot be disclosed without this written consent. I also understand that I may revoke this consent by written communication except to the extent that action has already been taken in reliance on it (i.e. information already disclosed). My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand. This authorization shall remain valid until revoked by me in writing.

Patient Signature (or Parent of minor/Legal Guardian): **X** _____ Date: _____

Some insurance companies use unprofessional methods to unfairly delay payment of your insurance claims. Be assured our office works diligently to obtain payment from your insurance company. However, in the event that your insurance company delays payment past 45 days, we may ask for payment directly from you to the extent allowed by our contract with your insurance company. West Lake Family Practice makes no claim to know what services your insurance covers. You may want to refer to your benefits manual or call you insurance directly if you have any questions about covered services.

FINANCIAL RESPONSIBILITY: I understand that I will be billed for any charges not paid by my insurance company within 60 days. I agree to pay for such charges within 30 days; I will be responsible for a 35% collection fee if payment is not received within a timely manner. I understand that charges for office services are payable at the time of service. Copayments, deductibles, and co-insurance amounts are payable at the time of service. I understand that West Lake Family Practice does not accept payment from third party payors such as PIP (Personal Injury Protection or from attorneys for accidents. I understand that I am financially responsible for all charges not covered under my health insurance benefits. I understand that any checks returned by the bank will be subject to a \$35.00 handling fee and that future visits may be on cash/credit basis. I understand that I may be billed \$35.00-\$75.00 for a Late Cancellation/No Show fee. I request that payment of benefits be made to West Lake Family Practice. I hereby authorize the release of any information necessary to determine liability for payment and obtain reimbursement on any claim. I further authorize the use of my signature below on all insurance submissions for services rendered or to be rendered. This authorization shall remain valid until revoked by me in writing.

I have read, understand, and agree to abide by the terms stipulated above. (Please read our patient brochure available at the receptionist window for more information about our practice.)

Patient Signature (or Parent of minor/Legal Guardian): **X** _____ Date: _____

Name of person completing form if other than patient: _____ Relationship to Patient: _____

How did you hear about us?: Friend Dr. Grimes/Messer Advertisement Yellow Pages Other