Patient Info & Authorization

First Name _____ MI_____ Last Name _____

Address_____

City_____ State_____ Zip_____

DOB: _____/_____/_____ Marital Status: S M D W

Home Ph._____ Work Ph._____ Cell Ph._____

Referring Phys: _____ Other Primary Care Phys: _____

Email address: _____

PATIENT'S AUTHORIZATION

I understand that initial screening services ordered by Referring Physician may warrant further diagnostic testing. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.

I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize the provider or designated representative to contact me by telephone or mail about appointments, billing and medical care. I authorize the physician to release any medical information required to process this claim.

I acknowledge that I have been offered a copy of the "Notice of Privacy Practices."

**** There is a $12 FEE for a DVD of images ($15 if mailed) to cover licensing and production cost****

Pt signature: _____ Date:_____

----------**Lines below are for use at additional (future) visits**----------

I confirm that changes to the above have been made in blue ink today:

Pt signature: _____ Date:_____

Pt signature: _____ Date:_____

Pt signature: _____ Date:_____

Pt signature: _____ Date:_____