SORRY WE DO NOT ACCEPT CHECKS OR MONEY ORDERS

BellaDonna Medical PC

TODAY'S DATE:

PATIENT INFORMATION

Patient ID:

Name: _____ Date of Birth: _____ Age: _____

Address: _____

City, State, and Zip Code: _____ APT# _____

Home Phone #: _____ Cell Phone #: _____

Social Security: _____ Marital Status: Married [ ] Single [ ]

Email: _____

Employer:_____Tele:#_____Occupation:_____

PHARMACY:_____TELE#_____

PHARMACY ADDRESS:_____ZIP CODE:_____

Who referred you to us: _____

INSURANCE INFORMATION

The primary insurance is my main insurance.

***Primary Medical Insurance:** _____ Policy #: _____

Name of Policyholder: _____ Date of Birth: _____

Self [ ] Spouse [ ] Child [ ] Other [ ]

SECOND INSURANCE:

Second Medical Insurance: _____ Policy #: _____

Name of Policyholder: _____ Date of Birth: _____

Self [ ] Spouse [ ] Child [ ] Other [ ]

IF YOU DO HAVE ANOTHER INSURANCE, PLEASE LIST ON THE BACK OF THIS SHEET.

ARE YOU COVERED BY ANOTHER INSURANCE OTHER THAN THE ONES LISTED YES [ ] NO [ ]

EMERGENCY CONTACT: PLEASE PROVIDE TWO (2) EMERGENCY CONTACTS

I authorize «OFFICE» employee to contact me in the event of an emergency, to confirm or cancel an appointment at the numbers listed above. If unable to get in touch with me, I further authorize «OFFICE» employee to contact the following person(s): EMERGENCY CONTACT:

Name: _____ **Name:** _____

Telephone # _____ **Telephone #** _____

PATIENT'S SIGNATURE:_____ TODAY'S DATE_____

Patient Name: _____ **Date:** _____

PLEASE PROVIDE THE RECEPTIONIST WITH ANY FORMS (INSURANCE, REFERRALS, ETC) PRIOR TO YOUR EXAMINATION

I herein authorize «OFFICE» to release my **IIHI (Individually Identifiable Health Information)** to my insurance company to obtain verification of insurance and benefits information each time I schedule a visit at «OFFICE». I also authorize «OFFICE» to call my insurance company regarding any outstanding claims.

«OFFICE» has agreed to accept my insurance. I authorize payment of any claims to be paid directly to «OFFICE». I further herein authorized release of my medical records and disclosure of my **IIHI** to my insurance company to aide in the processing of said claims.

In the event that my insurance, **«INSNAME» «INSADD1» «INSADD2» «INSCITY» and «SECINSNAME» «SECINSADD1» «SECINSADD2» «SECINSCITY»** does not pay, I authorize Belladonna Medical, PC to **ADJUDICATE** of my behalf to secure payment of all open claims. I further authorize Belladonna Medical, PC, to seek the assistance of and file a complaint with the Commissioner of Insurance.

I understand and agree that if my insurance terminates or is not accepted by «OFFICE», I will be fully responsible for all charges incurred. I further understand and agree that if I fail to meet my financial responsibility, I authorize the disclosure of my **IIHI** to any Collection Agency used by «OFFICE», to procure payment.

IF AT ANY TIME IN THE FUTURE YOU WANT TO REQUEST YOUR MEDICAL RECORDS, BE ADVISED THAT YOU WILL BE CHARGED .75 PER PAGE. AS A PROFESSIONAL COURTESY WE WILL FAX MEDICAL RECORDS TO ANOTHER PHYSICIAN (at no charge), AFTER WE OBTAIN FROM THAT PHYSICIAN YOUR SIGNED MEDICAL RELEASE AUTHORIZING US TO DO SO. PLEASE NOTE THAT MEDICAL RECORDS MAY TAKE UP TO TWO (2) WEEKS TO PREPARE AND RELEASE.

X _____ _____

Signature (if minor, patient and authorized guardian signature) ***Date***

I authorize «OFFICE» and/or its employees to provide in writing, reports, of my **IIHI (Individually Identifiable Health Information)** to others who may assist if my care, such as doctors, hospitals, medical facilities and labs.

I authorize «OFFICE» and/or its employees to release my medical information **(IIHI)** to my primary Care Physician:

Dr. _____

Address: _____

City, State and Zip Code: _____

Telephone #: _____ Fax #: _____

X _____ _____

Signature (if minor, patient and authorized guardian signature) ***Date***