MEDICARE PATIENT INFORMATION (please print)

Full Legal Name_____ Name you go by _____
First MI Last

Address_____
Street City State Zip

Home Phone_____ Cell Phone_____ SS#_____

Date of birth _____/_____/_____ Age _____ Sex _____ Marital Status_____

In Case of Emergency, who should be notified?_____ Phone_____

Did your doctor refer you? _____Yes _____No

Name of referring doctor _____Phone_____

MEDICARE INFORMATION

Is Medicare or a Medicare Advantage your primary insurance? _____Yes _____No

Do you or your spouse work in a company which has more than 20 Employees and have group insurance through the insurance at that job? _____Yes _____No

Are you covered by a HMO/PPO which makes Medicare secondary? _____Yes _____No

Are you covered by Medicare due to disability? _____Yes _____No

Is this illness covered by the Federal Black Lung or End Stage Renal Disease Program? _____Yes _____No

Is this illness due to an automobile accident? _____Yes _____No

Are you covered by Hospice? _____Yes _____No

Are you receiving Medicaid? _____Yes _____No

INSURANCE INFORMATION (WE NEED A COPY OF YOUR CARDS)

Primary Insurance_____	Secondary Insurance_____
Name of Insured_____	Name of Insured_____
Date of Birth____/____/____ Group _____	Date of Birth____/____/____ Group _____
Policy Number _____	Policy Number _____
Relationship to patient_____	Relationship to patient_____

(OVER PLEASE)

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____/_____/_____

Signature (name as it appears on Medicare Card) Date

If you have a supplemental policy and it is a supplemental policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized supplemental benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above supplemental carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____/_____/_____

Signature (name as it appears on supplemental card) Date

PAYMENT POLICY

We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% copayment. We do file with secondary / supplemental carriers. However, in the event that the secondary does not pay, patient will be billed for the balance.

You will be responsible for paying your annual deductible, copayment and charges for any non-covered or cosmetic services at the time of services. We accept Visa, MasterCard, Discover, personal checks, or cash.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in our office.

_____ _____/_____/_____

Signature Date