PLEASE PRINT CLEARLY WITH INK DATE:_____

PATIENT:

Social Security No:_____ D.O.B:_____ Age:_____ Sex: F / M

Name of Patient:_____ Name you go by:_____
Last First MI.

Address: _____
Street City State Zip

Primary Phone:(_____)_____ Alternate Phone:(_____)_____

Email Address:_____ Marital Status: Single Widow(er) Married Divorced

Occupation:_____Work phone:(_____)_____

Emergency Contact Name:_____Phone:(_____)_____

Relationship to Patient:_____

RESPONSIBLE PARTY: (If not self)

Patient's relationship:_____ Social Security No:_____

Name:_____
Last First MI.

Primary Phone:(_____)_____ Alternate Phone:(_____)_____

INSURANCE: (FOR LAB USE ONLY)

Company:_____Ins. ID #/Group #:_____

Pre-Approval Phone #:(_____)_____Medicare # (If applicable):_____

Please check (X) for the following: I give permission to the staff at Medical Options for Wellness to call and leave messages at my primary or alternate phone numbers listed above. I understand that a message may be left with a family member, co-worker, ect.

YES_____NO_____

Payments for all professional services are due at the time services have been rendered. There will be a fee charged for a missed appointment unless a minimum of **48 hours** notice is given. It is the goal of this office to provide the best possible medical care. In return it is your individual responsibility to pay in full for this care. Even though you may have insurance, you are solely responsible for the total amount. It is your individual responsibility to to file your insurance claim. Your insurance company will then pay any amount allowed by your policy directly to you: we do not accept payment assignment. This office does not fill out insurance forms, but will gladly provide you with the information necessary for you to file a claim. However, we cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. *Due to law requirements we are not able to accept patients that have bot Medi-care and Medi-cal insurance.*

I have read and understand the above paragraphs:

Print Name:_____ **Date:**_____

Signature of patient or of person legally responsible:_____

Revised: 07/13/2016