Center for Alternative Primary Care

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Patient Information

Name_____ Age_____
First Middle Last
Address_____
Street City State Zip Code
Home Phone (____)_____Work Phone(____)_____Cell Phone(____)_____
At which number can a message be left regarding appointment reminders? _____
DOB____/____/_____ Sex: M_____ F_____ SS#_____-_____-_____
E-Mail Address (for office updates/newsletter only) _____

_____

What is your relationship to the insured? Self_____ Spouse _____ Child _____
Patient's Employer_____ Phone _____
Company Address_____
Job Description _____
Spouse's Name _____ DOB____/____/____ SS#_____
Spouse's Employer _____ Phone _____
Company Address_____
Number of Children_____ Names and Ages_____
_____

In case of an emergency, who should be contacted? Name_____ Phone_____
Address _____ Relationship _____

_____

I understand and agree that health and accident insurance policies are an arrangement between the carrier and company. Furthermore, I will prepare any necessary reports and forms to assist in making collection from the insurance company and that any amount authorized to be paid directly to Center for alternative Primary Care, which will be credited to my account upon receipt. However, I understand that I am personally responsible for full payment for services rendered and/or for additional supplies/supplements. I understand that services rendered to me will be immediately due and payable. I also understand that I may have to satisfy a deductible (amount dictated by my health insurance company) and that the health insurance company may not pay for services rendered until my deductible has been met.

I hereby authorize the physician to diagnose and treat me (my dependent. minor child), and to request additional imaging or testing that is clinically indicated. I also authorize the physician to release any information to my health insurance company during the course of my examination or treatment.

Patient Signature_____ Date_____

Guardian or Spouse's Signature_____ Date_____

(I understand that in the event of my account going delinquent, interest will be accrued to my account balance. In the event of the necessity of professional collection services or attorney action, I will be responsible for reasonable and customary charges.)

Patient Signature_____Date_____