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ANNUAL UPDATE of PATIENT INFORMATION

*Please fill in **ALL** information below then SIGN & DATE*

Patient Name:_____ Social Security # :_____
Address:_____
Street City State Zip

Date of Birth:_____ Age:_____ Sex: _____ School:_____

Preferred Phone #:_____ May we leave messages? Yes No

Alt Phone #:_____ E-Mail Address:_____

Preferred contact method for appointment reminders: □ Preferred phone # □ E-Mail address □ Text to cell #

Legal Custody Information

□ Parents married, no custody issues □ Parents divorced, joint custody □ Parents divorced, mother custody □ Parents divorced, father custody □ Other Please Explain _____

Who has physical custody? _____ Who makes medical decisions? _____

Father:_____Address:_____

Occupation:_____Employer:_____

Mother: _____Address:_____

Occupation:_____Employer:_____

Guardian, if other than parent:_____

Occupation:_____Employer:_____

Who is authorized to pick-up prescriptions or correspondence?_____

Relationship to patient?_____

Primary Insurance:_____ _____Insurance Comp. Phone #:_____

Insurance ID#:_____Insurance Group #:_____

Policy Holder_____

Policy Holder Social Security #:_____Policy Holder DOB:_____

PAYMENT/INSURANCE AUTHORIZATION-AUTHORIZATION TO SEND REIMBURSEMENT INFORMATION

I accept responsibility for payment of charges for services rendered to the above named patient. I understand that full payment and/or my co-payment and/or deductibles are expected at the time services are rendered unless the doctor agrees otherwise. I understand that unless the named patient has coverage under a managed healthcare plan (i.e. HMO, PPO, and EAP) to which I subscribe and in which the doctor is a participated providers, I am personally responsible for the payment of all charges. I understand that as a courtesy this office will have my insurance claims filed but it does not release me of responsibility for payment of these charges. ***I understand that I may be charged $100 for a missed appointments not cancelled at least 24 hours in advance.*** I understand that any court order I have is an agreement between the courts and I- not the doctor, and I am still responsible for all payments. I also understand and agree that a collection agency and/or courts may be used in the event of delinquent payments and that I realize that such action could require the doctor to release to the collection parties involved information which identifies me, diagnosis, dates, services rendered and charges as well as any other information needed on the claim filed. In addition, if I have requested the doctor to have my charges filed to my insurance company I understand that securing benefits under health insurance or other health plans will require that the doctor provide plan management with confidential patient information including diagnosis, service dates, and type of services rendered. Further, I understand that for utilization review, quality assurance and other claim review purposes, it may require the doctor to provide my confidential information. I fully and freely consent to the release of any and all such patient information as is necessary for the processing and review of health claims made by or on behalf of the named patient. This consent shall remain in effect unless all claims have been fully processed and all review procedures completed.

X**Signature:**_____**Date:**_____

Parent/guardian or Patient if 18 years of age