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Today's Date:				PCP:		
PATIENT INFORMATION						
Patient's Last Name: First: Middle			Mrs. Mr.	Miss Ms.	Marital status: Single Mar Div Sep Wid	
Is this your legal name? Yes No	If not, what is your legal name?	(Former name):		Birth date:	Age:	Sex:
Street address:		Social Security no.:		Home Phone #: Cell Phone #:		
P.O. box:	City:		State:	ZIP Code: (include 4 digits)		
Occupation:	Employer:			Employer phone no.:		
PHARMACY NAME:		ADDRESS:		PHONE:	FAX:	
Email:			Dr.	Insurance plan	Hospital	
Family	Friend	Close to home/work	Yellovv Pages	Other		
EMERGENCY CONTACT (Name & contact phone#):						
INSURANCE INFORMATION						
(Please give your insurance card and Drivers License or Picture ID to the receptionist.)						
Person responsible for bill: Birth date:		Address (if different):		Home phone no.:		
Is this person a patient here? Yes No						
Occupation:	Employer:	Employer address:		Employer phone no.:		
Is this patient covered by insurance? Yes No						
Please indicate name of PRIMARY insurance:						
Subscriber's name:	Subscriber's S.S. no Birth date:		Group no.:	Policy no.:	Co-payment:	
Patient's relationship to subscriber:	Self	Spouse	Child	Other		
Name of SECONDARY insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:		
Patient's relationship to subscriber:	Self	Spouse	Child	Other		
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the TUYA PA:						

I understand that I am financially responsible for any balance. I also authorize Tuya PA or my insurance company to release any information required to process my claims.

SELF PAY PATIENTS:
Those who pay CASH will receive a 20% discount if account is paid in full at time of service. This DOES NOT apply to those patients whom we are filing insurance for, only patients that do not have insurance coverage and are considered selfpay.

HEALTH INSURANCE OFFICE POLICY: It is the patient's primary responsibility to know which lab, imaging facility, hospital etc. that is in network with their individual insurance plan. Insurers frequently change their benefits and coverage for patients and do not always provide our office with prior notification of the changes; due to this it is also the patient's responsibility to know what their co-payments are and or deductibles are at the time of the office visit. Our office will assist the patient to the best of our ability with verification of benefits. It is also our office policy to collect at time of service for all co-payments and or deductibles; we do not bill or collect payments for office visits.

OFFICE POLICIES:
Tuya PA has hours of operation Monday Through Thursday from 8am to 5pm and Friday 8am to 12pm. There will be an oncall physician available for emergencies only through the after-hour's answering service. In the event of inclement weather conditions that enable travel on the causeways, telephone assistance will be provided during the above noted operating hours, and the on-call options also apply. I understand that three missed appointments without 24-hour notification may result in dismissal from the practice. Missed appointments will also be subjected to a $50 charge if more than 2 appointments are missed without 24-hour prior notification of cancellation. It is our policy to collect all co-pays, deductibles & co-insurances at the time of the visit, at check-in before being seen. We will make every effort to ensure that these amounts are correct. If you are unable to make these payments, at the time of the service, we will have to reschedule your appointment. A charge of $30.00 will be charged on all RETURNED CHECKS. ** PLEASE NOTE: if your account becomes delinquent or unpaid for more than 60 days without confirmation of a payment agreement, we reserve the right to discharge you from the practice due to non-compliance.

LABS, IMAGING AND SPECIALIST PHYSICIAN REFERRALS - ORDERED BY PHYSICIAN DISCLAIMER:
please note that all Labs and or Imaging ordered by the physician will require a follow up appointment to discuss results; this must be done within two weeks of the testing. It is the patient's primary responsibility to know which lab is in network with your individual insurance plan, and please make sure that a follow up appointment is made and kept; if cancellation occurs the patient must follow up with a rescheduled date. The physician does not assume responsibility for the patient's inability to follow up after testing has occurred. It is also the patient's responsibility to notify the office if they do not receive appointments for testing and or referrals within two weeks of the office appointment where the referral was generated. I have read and understand this information and accept responsibility.

MEDICATION REFILL STATEMENT:
I am aware that requests for refills including antibiotics and pain medications are to be made during business hours.

Patient/Guardian signature: _____ Date: _____