PATIENT INTAKE FORM

Today's Date ____/____/____

PATIENT INFORMATION (*Please Print*)

Name _____
Last First Middle

Address _____
Street City State Zip

E- Mail Address _____

Gender _____ Marital Status _____ Date of Birth _____/_____/_____ SS # _____-_____-_____

Person responsible for paying your bills (only if you are a minor or have a guardian)

Name: _____ SS # _____
Last First MI Relationship to Patient

Address _____
Street City State Zip

Home Phone (_____) _____ Cell Phone (_____) _____

How may we contact you?

Y / N Home Phone (_____) _____ Cell Phone (_____) _____ Y/N Text Message Y/N E-Mail

Y / N Work Phone (____) _____ Employer's Name _____

Y / N May we leave personal medical information on your answering machine at home?

Y / N Do you give our office permission to discuss your medical information with family members? If yes, please provide their names and phone numbers below. Please start with your nearest friend or relative that you would like for your emergency contact:

Name: _____ Relationship to you: _____
Daytime Phone (_____)_____ Evening Phone (_____)_____

Name: _____ Relationship to you: _____
Daytime Phone (_____)_____ Evening Phone (_____)_____

BILLING INFORMATION: Do you have health insurance? □ Yes □ No

Primary Insurance Carrier: _____Insured's Date of Birth: ____/____/____
Name of Insured: _____ Insured's SSN # : ____/____/____
(exactly as it appears on insurance card)
Secondary Insurance Carrier: _____ Insured's Date of Birth: ____/____/____
Name of Insured: _____ Insured's SSN #: ____/____/____
(exactly as it appears on insurance card)

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. I have had an opportunity to review the practice's (a) Financial Policies and (b) Notice of Privacy Practices. I understand that I also may request of copy of either of these notices.

Dr. Gardner is a participating provider for most major insurance plans. As a courtesy, we will contact your insurance company to verify insurance eligibility and benefits before your appointment. We will also file an insurance claim for covered services if Dr. Gardner is considered in-network with your plan. Please remember that your medical insurance is a contract between you and your insurer, and any questions regarding coverage should be directed to your insurer. It is your responsibility to know how your insurance policy works. If we file an insurance claim for you, and that claim is rejected due to incorrect information given to us, you will be responsible for the balance. The portion that your insurer designates as "patient responsibility" – co-pay, coinsurance, and any unmet deductible – will be collected at the time of service. You will be notified of any remaining balance after insurance by paper statement. It is your responsibility to notify us of any changes in contact information, e.g., telephone number and address.

We accept cash, checks, and all major credit cards. We will accept commercial or business credit cards with an additional $5 fee. A $25 fee will be assessed for checks returned by your bank. If a second statement goes unpaid for longer than 30 days, your account will be forwarded to a collection agency. A $25 or 50% collections fee, whichever is greater, will be added to the outstanding amount owed to us.

Signature of Patient or Responsible Party: _____ **Date** ____/____/____

Please present your insurance card(s) and your photo identification (driver's license) to the receptionist. The receptionist will make a copy and return them to you promptly.