PATIENT INFORMATION

DATE _____ PHARMACY_____#_____

GUARANTOR NAME _____SEX_____ DOB _____

ADDRESS _____HOME PHONE_____

CITY – STATE _____ZIP _____SOCIAL SECURITY #_____

HOW WERE YOU REFERRED TO OUR OFFICE?_____

EMERGENCY CONTACT(S):_____PHONE_____
_____ PHONE_____

PATIENT(S):
CHILD NAME _____SEX_____ DOB _____ SS #_____
CHILD NAME _____SEX_____ DOB _____ SS #_____
CHILD NAME _____SEX_____ DOB _____ SS #_____
CHILD NAME _____SEX_____ DOB _____ SS #_____
CHILD NAME _____SEX_____ DOB _____ SS #_____

ADDRESS (if <u>different</u> from Guarantor)_____

<u>INSURANCE INFORMATION:</u>
PRIMARY INSURER_____ PLAN_____ID#_____CO-PAY$_____
SECONDARY INSURER_____ PLAN_____ID#_____CO-PAY$_____
OTHER INSURANCE_____ PLAN_____ID#_____CO-PAY$_____

SUBSCRIBER NAME:_____SS#_____ DOB_____
EMPLOYER NAME, ADDRESS & # _____

ONE OF THE BELOW MUST BE CHECKED BEFORE VISIT:
I WILL BE PAYING TODAY BY: ☐ **CASH** ☐ **CHECK** ☐ **CREDIT CARD**

<u>SIGNATURE ON FILE</u>

PLEASE READ CAREFULLY AND SIGN:
I request that payment of authorized benefits be made either to me or on my behalf to Alliance Medical Group, Inc. for any services furnished to me by that physician / supplier. I authorize any holder of medical information about me to release to CMS and its agents, or any other supplier of medical benefits, any information needed to determine those benefits, or the benefits for related services.

I understand that regardless of any insurance coverage I may have, it is my responsibility to pay my bill. I further understand that my insurance is designed to reimburse Alliance Medical Group, Inc. for covered expenses. I understand further that not all services are covered by Medicare or other insurance plans and acknowledge that I am responsible and will pay for those services. I agree to pay all costs of collection, including a reasonable attorney's fee, incurred in the collection of any amounts not paid, as required above.

_____
PATIENT OR RESPONSIBLE PARTY