PATIENT INFORMATION

LAST NAME_____ FIRST NAME_____ MI _____

( ) MALE ( ) FEMALE SS# _____ DOB_____

ADDRESS_____

CITY_____ STATE____ ZIP CODE_____

(C)PHONE#_____ (W)PHONE# _____

(H)PHONE#_____

EMAIL ADDRESS_____

WHO REFERRED YOU OR HOW DID YOU HEAR ABOUT US _____
(If a patient referred you, may we have your permission to write them a thank you? Yes_____No____

PRIMARY INSURANCE INFORMATION

INSURANCE NAME_____ INSURANCE PHONE NO. _____

GROUP #_____ POLICY #_____

EMPLOYER_____ POLICY HOLDERS NAME_____

POLICY HOLDER DOB_____ POLICY HOLDERS SSN _____

SECONDARY INSURANCE INFORMATION

INSURANCE NAME_____ INSURANCE PHONE NO. _____

GROUP #_____ POLICY #_____

EMPLOYER_____ POLICY HOLDERS NAME_____

POLICY HOLDER DOB_____ POLICY HOLDERS SSN _____

I hereby acknowledge that the insurance company above is my current insurance and that I have given a copy of my insurance card for my file. Should I need lab work, it will be sent to a laboratory. If the above information is not correct, or it is not a covered benefit with my insurance, I understand I am responsible for payment to Columbine Family Practice, P.C. or the lab.

I hereby authorize my insurance benefits to be paid directly to Columbine Family Practice, P.C., realizing I am responsible for all non-covered services. I also understand that if I have a secondary insurance carrier this office will process claims as a courtesy to me, but the ultimate responsibility for payment to facility/physician is mine. As it is often necessary to forward medical information for claims payment, I hereby authorize the release of any medical information to the insurance carrier for payment of claims.

_____ _____
Signature of patient/responsible party Date

COLUMBINE FAMILY PRACTICE, P.C. - FINANCIAL POLICY

Just as we are dedicated to providing you with the best possible medical care, we are also committed to extend this same level of service with regard to our business and financial policies. It is crucial that you understand these policies especially in view of the ongoing changes in the health care industry today. These changes may affect you in the services that are covered by your insurance carrier or in services that are determined to be due and payable directly by you.

Payment is due at the time of the service, unless arrangements have been made in advance or you have insurance coverage for which we are a contracted provider. If insured, copayments are due at check in, as this is part of your contract with your insurance carrier. If you are not able to pay your copayment at the time of your visit, we will need to reschedule your appointment. We accept Visa, MasterCard, Discover, American Express, cash and checks. Any patient balance for deductibles or coinsurance that is showing due will also be collected at the time of the appointment during check in.

Keep in mind that your insurance policy is a contract between you and your insurance company, and as the patient you are ultimately responsible for payment for services rendered. If your account should become delinquent or sent to an outside collection agency, you will be responsible for all costs incurred in collecting the account and you will be required to pay your account in full before scheduling an appointment.

I have read and understand this Financial Policy Agreement and I agree to be bound by its terms.

_____ _____

Signature of patient/Responsible Party Date