**PATIENT INFORMATION**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name (Last, First, MI)** | | | | | | **Age: |Language:** | | | **Sex: |Race:** |
| **DOB:** | | **SSN:** | |
| **Marital status:** | | | **Driver’s licence No.:** | | | | | | |
| **Street:** | | | | **City, State, Zip:** | | | | | |
| **Mobile:**  **Res:** | | | | | **Other Ph:**  **Email:** | | | | |
| **Occupation:** | **Employer’s name & address:** | | | | | | | | |
| **Emergency contact:** | | **Relationship:** | | | | | **Contact number:** | | |
| **Reason for visit:** | | | | | **Referred by:** | | | | |
| **Primary care physician:** | | | | |

**RESPONSIBLE PARTY INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name (Last, First, MI)** | | | **DOB:** | **SSN:** |
| **Relationship:** | |
| **Street:** | **City, State,Zip:** | | | |
| **Mobile:**  **Res:** | | **Other Ph:**  **Email:** | | |
| **Employer’s name & address:** | | | | |

**INSURANCE INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Company name | Member ID # | Group ID # | Insurance phone |
| Primary insurance |  |  |  |  |
| Secondary insurance |  |  |  |  |

**CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT**

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. IN ORDER TO CONTROL YOUR COST OF BILLING, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS ARE PAID AT THE CONCLUSION OF EACH VISIT. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney’s fees and costs of collection.

* To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient’s record.
* I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to DR. KRISTIN EGAN M.D.
* This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.
* The undersigned consents to any medical or surgical treatment, laboratory services, or audiology services rendered the patient under the general and specific instructions of the physician.
* A **$50 cancellation fee** will be applied to your account if you miss or cancel your appointment with **less than 24 hours notice**.

|  |  |
| --- | --- |
| **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Witness:** | **Relationship to patient:** |