FINANCIAL INFORMATION

Patient Name _____ **Today's Date** _____

Primary Insurance Information

Name of insurance company _____
Group number _____
ID # or SS # _____
Who is the person that holds the insurance? _____
_____
Who is covered by this insurance? _____
_____
Effective date of insurance _____
Copay? Yes No How much? _____

We must have a copy of your current insurance card

Secondary Insurance Information

Name of insurance company _____
Group number _____
ID # or SS # _____
Who is the person that holds the insurance? _____
_____
Who is covered by this insurance? _____
_____
Effective date of insurance _____
Copay? Yes No How much? _____

We must have a copy of your current insurance card

Who is responsible for any charges not paid by insurance?

Name _____
Address _____
Home phone _____
Work phone _____
Cell phone _____
Relationship to patient _____
SS # _____
Employer _____
Work address _____
_____
_____

The following must be read and signed:

Assignment of Benefits
I authorize payments of medical benefits to my provider for professional services rendered.
Signed _____

Release of Information
I authorize the release of any information acquired in the course of my treatment, which is necessary to determine benefits or coordinate my care.
Signed _____

Financial Responsibility
This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay services rendered. I agree to reimburse the fees of any collection agency (up to 33% of the debt), and all costs, expenses, and reasonable attorney fees we incur in such collection efforts.
Signed _____

Insurance Coverage
I understand that it is my responsibility to understand my insurance coverage and inform my doctors of any changes in that coverage. This includes knowledge of services covered, facilities to be utilized, etc.
Signed _____

Office Providers
I understand that Elizabeth M. Bassow-Scheve M.D., P.C. employs physicians and physician assistants (PAs) as providers in the practice. I acknowledge and accept the possibility of treatment by either in the office or on-call for medical emergencies. I have received and read a copy of the practice brochure and cancellation/no show policy.
Signed _____

Care for Minors
I understand that under certain circumstances my minor child can consent to medical care without parental consent
Signed _____