BILLING INFORMATION (EMAIL REQUIRED to Receive Office Information, Medical Reports, etc.)

PATIENT INFORMATION **DATE: _____**

DRIVER'S LICENSE: _____ STATE:_____

Please Write Clearly & Complete all Sections

NAME:_____
Last First Middle Initial

HOME ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

SOCIAL SECURITY #:_____-_____-_____ SEX: M / F AGE:_____

BIRTHDATE:_____/____/_____ MRD____SGL____DIV____SEP____WID____

ETHNICITY: ( ) Hispanic ( ) Non-Hispanic ( ) Other

RACE:( )White ( )Black ( )Hispanic ( )Asian ( )Other

Race & Ethnicity is required by Medicare / Insurances

Preferred Language:( )English ( )Spanish ( )_____

HOME PHONE (_____) _____-_____

CELL PHONE (_____) _____-_____

WORK PHONE (_____) _____-_____

EMAIL:_____

EMPLOYER:_____

PROFESSION:_____

WORK ADDRESS: _____

CITY:_____ZIP_____

SPOUSE OR FATHER OR GUARANTOR INFORMATION

NAME:_____
Last First Middle Initial

HOME ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

SOCIAL SECURITY #:_____-_____-_____ SEX: M / F AGE:_____

BIRTHDATE:_____/____/_____ MRD____SGL____DIV____SEP____WID____

HOME PHONE (_____) _____-_____

CELL PHONE (_____) _____-_____

WORK PHONE (_____) _____-_____

EMAIL:_____

EMPLOYER:_____

PROFESSION:_____

WORK ADDRESS: _____

CITY:_____ZIP_____

SPOUSE OR MOTHER OR GUARANTOR INFORMATION

NAME:_____
Last First Middle Initial

HOME ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

SOCIAL SECURITY #:_____-_____-_____ SEX: M / F AGE:_____

BIRTHDATE:_____/____/_____ MRD____SGL____DIV____SEP____WID____

HOME PHONE (_____) _____-_____

CELL PHONE (_____) _____-_____

WORK PHONE (_____) _____-_____

EMAIL:_____

EMPLOYER:_____

PROFESSION:_____

WORK ADDRESS: _____

CITY:_____ZIP_____

LIST ALL CHILDREN. INDICATE IF LIVING AT HOME

	NAME	SEX	HOME	DOB		NAME	SEX	HOME	DOB
1.	_____	M / F	Y/N	_____	5.	_____	M / F	Y/N	_____
2.	_____	M / F	Y/N	_____	6.	_____	M / F	Y/N	_____
3.	_____	M / F	Y/N	_____	7.	_____	M / F	Y/N	_____
4.	_____	M / F	Y/N	_____	8.	_____	M / F	Y/N	_____

EMERGENCY CONTACTS
NOT LIVING AT HOME

NAME:_____

PHONE (____) _____-_____

NAME:_____

PHONE (____) _____-_____

HOW ARE YOU PAYING FOR SERVICES RENDERED TODAY AND IN FUTURE?

CASH_____CHECK_____CREDIT CARD_____PPO/HMO_____ CARE CREDIT_____

UPDATE INSURANCE INFORMATION / ADDRESS / PHONE # AT EACH VISIT

I will Update the Office with any Changes to my Insurance / HMO Information / Address & Phone at Each Visit. I will be Responsible for All Fees and Charges Incurred by me or my dependents. *RESPONSIBLE PARTY INITIALS:_____*

How did you find us? _____

PRESENT YOUR INSURANCE CARD AT FRONT DESK

INSURANCE CO._____

_____

SUBS ID#_____

SUBS NAME_____

GROUP#_____

FINANCIAL AND BILLING POLICY AGREEMENT

I AUTHORIZE TREATMENT OF MY SPOUSE & DEPENDENT CHILDREN. I AGREE TO PAY ALL FEES & CHARGES FOR THEIR TREATMENT, AT TIME OF SERVICE. IF MY INSURANCE OR MEDICARE DOES NOT COVER CERTAIN COVERED CHARGES OR DOES NOT PAY IN A TIMELY MANNER, I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT IN FULL FOR ALL CHARGES. I AM RESPONSIBE TO FIND OUT WHY MY INSURANCE COMPANY IS NOT PAYING. I AUTHORIZE PAYMENT OF ALL INSURANCE BENEFITS TO SHIVINDER S. DEOL MD INC. DBA ANTI-AGING & WELLNESS CENTER FOR ALL SERVICES PROVIDED. I AUTHORIZE RELEASE OF INFORMATION TO MY INSURANCE COMPANY & APPROPRIATE AGENCIES PER HIPAA. I UNDERSTAND THAT IF MY ACCOUNT IS TURNED OVER TO COLLECTION, THERE WILL BE $25.00 FEE IN ADDITION TO THE MONTHLY FINANCE CHARGE OF 18% PER ANNUM. IF I CONSENT TO BUY ANY SUPPLIES, OR HAVE ANY UNCOVERED OR MEDICALLY UNNECESSARY PROCEDURES DONE, THEN I WILL BE RESPONSIBLE TO PAY FOR THESE CHARGES AT TIME OF SERVICE. THESE UNCOVERED SERVICES ARE NOT BILLED TO MEDICARE / INSURANCE.

SIGNATURE_____DATE_____

PATIENT / PARENT / OR RESPONSIBLE PARTY (PRINT NAME)