



PATIENT INFORMATION

PATIENT'S NAME _____ (LAST) _____ (FIRST) _____ (MI) _____ (NICKNAME)

DOB ____ / ____ / ____ SOCIAL SECURITY # ____ - ____ - ____ MARITAL STATUS _____ MALE FEMALE

ADDRESS _____ (STREET) _____ (CITY, STATE) _____ (ZIP CODE)

HOME PHONE (____) ____ - ____ CELL PHONE (____) ____ - ____ WORK PHONE (____) ____ - ____

NAME OF SPOUSE OR PARENT _____ PATIENT'S EMPLOYER _____

ADDRESS _____ ADDRESS _____

REFERRING PHYSICIAN _____ FAMILY DOCTOR _____ PHONE # (____) ____ - ____

INSURANCE INFORMATION

PRIMARY INSURANCE CO. _____ POLICY # _____

NAME OF INSURED PARTY _____ DOB: _____ S.S. # ____ - ____ - ____

SECONDARY INSURANCE CO. _____ POLICY # _____

NAME OF INSURED PARTY _____ DOB: _____ S.S. # ____ - ____ - ____

I understand that I am financially responsible for all charges for services to me, including co-payments, co-insurance, out-of pocket and deductibles. I authorize payment of medical benefits and I assign benefits payable to Medical Associates of Brevard for professional services rendered. I understand that I will receive statements, reflecting my account balance and that the FINAL PAYMENT of this account is my responsibility. Furthermore, should I default on payment for services rendered I agree to pay all collection costs including reasonable attorney's fee. **Please be advised that your insurance has been verified but is not a guarantee of payment.** This signature and assignment is to be a continuing one, remaining in effect until revoked in writing by the undersigned.

SIGNED _____ DATE ____ / ____ / ____

HIPAA RELEASE

I authorize Medical Associates of Brevard to discuss my health care with and/or leave a detailed message on my answering machine:

_____ (NAME) _____ (RELATIONSHIP)

_____ (NAME) _____ (RELATIONSHIP)

SIGNED _____ DATE ____ / ____ / ____