# PATIENT INFORMATION

Patient's Name ______________________________

Date of Birth ____________________ Age ____________ Male / Female ________

Address ______________________________ Home Telephone ______________

City ____________________ State ____________ Zip Code ______________

E-mail Address ______________________________ Cell Phone ______________

Marital Status ____________ Race ____________ Ethnicity (Nationality) ______________

Social Security Number ______________ Driver's License number ______________

Employer ____________________ Occupation ______________

Employer's Address ______________________________ Work Telephone ______________

Person to Pay for Services ______________________ Relationship ______________

Address ______________________________ Home Telephone ______________

City ____________________ State ____________ Zip Code ______________

Spouse's Name ____________________ Spouse's Employer ______________

Preferred Language ________ Referred By Internet Insurance Directory Friend or Family ______________ Other ________

Who may we thank for the referral?

How would you like to be contacted? Home Phone Cell Phone Letter via US Postal Service (Secure E-mail in the future)

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## INSURANCE INFORMATION

**Insurance Company (1)** ______________________________

Policy Holder's Name ______________________________ Date of Birth ______________

Policy Number ____________________ Group Number ______________

Address to which Claims are sent ______________________________

City ____________________ State ____________ Zip Code ______________

**Insurance Company (2)** ______________________________

Policy Holder's Name ______________________________ Date of Birth ______________

Policy Number ____________________ Group Number ______________

Address to which Claims are sent ______________________________

City ____________________ State ____________ Zip Code ______________

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## ASSIGNMENT OF BENEFITS

I hereby assign all medical and / or surgical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and other health plans to North San Antonio Healthcare Associates. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement shall be considered as valid as the original. I hereby authorize assignee to release all information necessary to secure payment.

Signed ______________________________ Date ______________

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## FINANCIAL AGREEMENT

The charge for medical services rendered will be billed to the listed insurance carrier(s) for payment, if this insurance information is adequately provided. Whether signing as the patient or his/her agent, I agree that in consideration of the services rendered, all information provided is correct and I shall be individually responsible to pay North San Antonio Healthcare Associates for all services at the regular rates and terms should my insurance company deny payment. I shall also be responsible for any deductibles or co-pay amounts owed at the time of service. I understand that any account must be paid in full 90 days from the date of service, if not by the insurance carrier, then by me, as the responsible party. Should this account be referred for collection to any attorney or collection agency, I shall pay all attorney's fees and collection expenses in connection therewith, if the patient's account is delinquent.

Signed ______________________________ Date ______________