Welcome To EmergiCare

Patient Name: ____Today's Date: ___________________
First Middle Last
Home Address: ____
City: _________________________________ State: _____________ Zip: ____________________
Telephone: ( ) ________________________ May information be left on answering machine? Y / N
Birth date: ________________ Age: ________ Sex ______ SSN: ______________________________
Email Address: ____ May send information here? Y / N
Employer: ______________________________________ Occupation: _________________________
Employer's Address: ____
City: ___________________________________ State: ____________ Zip: __________________
Work Phone: ( ) _______________________________ May we contact you at work? Y / N

Complete this section only if someone <u>other than the patient</u> is financially responsible.

Responsible Party: ____________________________ Relationship to Patient: ______________________
Address (if different from above): ____
Telephone( )_____________________________May information be left on answering machine? Y / N
Birth date: _______________________ Age:__________ SSN:______________________________
Employer: ___________________________________ Work Phone: ( ) __________________________
Employer's Address: ____
City: _________________________________ State: ____________ Zip: ____________________

I grant permission for ________________________________ (name/relationship) to receive information regarding my diagnosis and treatment. ***Initials__________***

Emergency contact person: ___________________________ Relationship: _________________________
Home Phone: ( ) _______________________________ Work Phone: ( ) _____________________

How did you learn about our practice? ____

Major Complaint______________________________ Date of Injury or Onset of Illness ______________

Did your injury happen on the job? Y / N Did you report the accident to your employer? Y / N

<u>Payment in full is expected for your visit today</u>.

What method of payment will you use today? _____Cash _____Check ____Credit Card

____________________________________ ______________________________
Signature of Patient or Responsible Party Date

Initial and date that your information has not changed and you still agree to our conditions and terms our financial policy.

_______ _________ _________ ________ _________ ________ _______ _______

Insurance Information

Patient's Name:____ Today's Date:________________
First Middle Last
Name of Insurance Company: ____
Address: ____
City: ___________________________ State: ________ Zip: _____________ Phone:_______________
Insured's Name: ______________________________ Insured's Date of Birth _____________________
Insured's SSN: _______________________________ Group Number: __________________________
Policy ID Number: _______________________

Our office will file to our contracted insurances for all reimbursable services. For non-contracted insurance companies, payment in full is due at the time of service. We will file with your insurance as a courtesy to allow them to reimburse you any benefits due. We will not file secondary insurances. Please remember that you are responsible for any deductible, copay, and non-covered service amounts.

Financial Policy

I hereby grant permission to the EmergiCare medical staff to perform such medical/surgical procedures they deem necessary. I authorize information and subsequent visits to be relayed verbally, written, or faxed to my family doctor, commercial insurance company, employer, and/or work comp Insurance carrier, if applicable.

I understand that EmergiCare is not a participating provider for Medicare or Medicaid. I certify that I am not a Medicare/Medicaid recipient, I also understand that if I am a Medicare/Medicaid recipient that I will not be reimbursed for my visit at EmergiCare.

I understand that if I am a guardian accompanying a minor, I am responsible for payment. I understand that all accounts are due and payable at the time of service if EmergiCare is not a participating provider with my Insurance Carrier.

I hereby authorize my representing Insurance Carrier to pay any benefits for my care to EmergiCare directly, if EmergiCare is a participating provider or if this is a Workers Compensation case.

I understand that even though I may have an insurance claim pending, I ultimately remain responsible for the account balance. EmergiCare does not accept responsibility for collecting an insurance claim or for negotiating a disputed claim.

(Insurance reimbursement is a contract between you and your carrier. You are responsible for payment of your account within the usual limits of our credit policy.)

Any returned check will be subject to a $25.00 returned check fee. I agree to pay an additional 10 percent late charge on the account balance if my self-pay or balance after insurance is not received within 30 days of my first statement date. I agree that if my account is referred to a collection agency, I will pay an additional administration fee of 30 percent of the account balance. Court cost and attorney fees incurred in connection with the collection of my account will also be my responsibility

I have read this policy and agree to the terms within for services rendered.

Signature____________________________________ Date:_________________________________

WORK COMP PATIENTS ONLY-PLEASE READ AND SIGN

1. The EMPLOYEE is responsible to report to Work Comp Injury, in writing, within four (4) days.
2. The EMPLOYER is responsible to fill out and mail a first report of injury to their insurance carrier within 10 days of injury notification.
3. The INSURANCE CARRIER is responsible to pay within 30 days of receiving the Work Comp bill.
4. If the EMPLOYER fails to file the first Report of Injury, the employee must file his/her own first report of injury or be responsible for the bill.
5. If the INSURANCE CARRIER "denies" the claim for any reason, the patient will be responsible for the bill.

Signature____ Date: _______________________________________