PATIENT INFORMATION

PATIENT NAME_____ DATE OF BIRTH_____

SEX_____ MARITAL STATUS_____

NAME OF RESPONSIBLE PARTY IF NOT SAME AS ABOVE_____

RESPONSIBLE PARTY

ADDRESS_____ CITY_____

STATE_____ ZIP_____SS#_xxx-xx-___ ___ ___ _ __

HOME PHONE NUMBER_____WORK_____

CELL #_____E-MAIL_____

If you provide your email, it may be used for appointment reminders and our newsletter.

SKYPE Account _____

EMPLOYER_____PHONE_____

Address_____City_____State_____Zip_____

EMERGENCY CONTACT PERSON _____

Relationship_____Phone_____

HOW DID YOU HEAR ABOUT US? _____

PRIMARY CARE PHYSICIAN_____PHONE _____

ALL FEES ARE DUE ON THE DAY OF SERVICE.

I UNDERSTAND THAT THE OUR SERVICES CONTAIN MANY TESTS/PROCEDURES THAT ARE NOT COVERED BY INSURANCE, AND THAT GROSSMAN WELLNESS CENTER DOES NOT PARTICIPATE IN ANY INSURANCE PLANS, OR MEDICARE, NOR BILLS INSURANCE. IF I SUBMIT THE CHARGES TO MY INSURANCE COMPANY FOR REIMBURSEMENT, I AUTHORIZE THE RELEASE OF ANY INFORMATION REQUIRED TO PROCESS INSURANCE INQUIRIES FOR SERVICES RENDERED. SHOULD MY ACCOUNT BE REFERRED TO A COLLECTION AGENCY, THE COUNTERSIGNED SHALL PAY A $50 COLLECTION FEE, AND AN INTEREST RATE OF 1.5% PER MONTH MAY APPLY TO ANY UNPAID BALANCES.

DATE_____PATIENT SIGNATURE_____