PATIENT INFORMATION: PLEASE PRINT

NAME: _____ GENDER M F DATE OF BIRTH _____
FIRST INTIAL LAST

ADDRESS _____
STREET CITY ZIP

PHONE _____

INSURANCE INFORMATION YOUR INSURANCE CARD AND DRIVERS LIC MUST BE PRESENTED AT TIME OF SERVICE

PRIMARY INSURANCE _____ SUBSCRIBERS NAME _____

SUBSCRIBERS DATE OF BIRTH _____ REALTIONSHIP TO PATIENT _____

PLACE OF EMPLOYMENT _____

SECONDARY INSURANCE _____ SUBSCRIBERS NAME _____

SUBSCRIBERS DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

PLACE OF EMPLOYMENT _____

EMERGENCY CONTACT _____ PHONE # _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY MEDICAL CLAIMS. I PERMIT A COPY OF THE AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. I HEREBY AUTHORIZE MEDPLUS AFTER HOURS CLINIC TO APPLY FOR BENEFITS ON MY BEHALF FOR SERVICES RENDERED BY MEDPLUS OR THEIR ORDER. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER PAID OR NOT BY SAID INSURENCE.

MEDPLUS AFTER HOURS CLINIC'S HIPPA POLICY IS VIEWABLE UPON REQUEST TO THE RECEPTIONIST

I AUTHORIZED MEDPLUS TO DISCLOSE MY MEDICAL RECORDS AND HEALTH INFORMATION (FOLLOWING HIPPA REGULATIONS) TO THE PARTIES LISTED BELOW:

FAMILY PHYSICIAN _____

LEAVE MESSAGES ON ANSWERING MACHINE YES OR NO

LIST ANY FAMILY MEMBERS YOU WOULD ALLOW US TO PROVIDE MEDICAL INFORMATION OR FINANCIAL INFORMATION TO INCLUDING INSURANCE HOLDER:

1. _____ 2 _____

_____ DATE _____
SIGNATURE OF PATIENT OR GUARDIAN

IF YOUR ACCOUNT IS REFERRED TO OUR COLLECTIONS DEPT THERE WILL BE A FEE OF $ 25 PER INCIDENT

THIS FORM MUST BE FILLED OUT IN FULL FOR PAYMENT FROM YOUR INSURANCE COMPANY