Patient Information

PATIENT NAME_____ Date of Birth: _____

Address:_____City: _____ State/Zip Code:_____

Cell Phone: _____ Home Phone: _____

E-MAIL: _____

Employment:_____ Work Phone:_____

HUSBAND/PARENT: _____ Date of Birth: _____

Address:_____City: _____ State/Zip Code:_____

Cell Phone: _____ Home Phone: _____

Employment:_____ Work Phone:_____

EMERGENCY CONTACT #1_____ Phone: _____

EMERGENCY CONTACT #2_____ Phone: _____

Family Physician: _____

MEDICAL ALLERGIES: _____

PREFERRED PHARMACY: _____

INSURANCE

Policy Holder:_____ Insurance Company: _____

ID Number: _____ Group No. _____

AUTHORIZATION TO MAIL, CALL OR EMAIL

I certify that I understand and am responsible for the privacy risk of the mail, phone calls, and emails. I hereby authorize a representative or physician of this office to mail, call or email me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying this office to that effect in writing.

_____ _____

SIGNATURE **DATE**

MEDICARE BENEFICIARY SIGNATURE ON FILE FORM

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulation pertaining to Medicare assignment of benefits apply.

_____ _____

SIGNATURE **DATE**

M.TERRY JEPPSON M.D. FACOG
OFFICE INSURANCE POLICY

PLEASE SHOW YOUR INSURANCE CARD TO THE RECEPTIONIST

I do understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account. I agree to pay ALL re-billing charges, interest charges, collection cost and reasonable legal fees. I request that payment under the medical insurance program be made to the provider of medical services. I authorize the provider to release to my insurance carrier any information needed for those claims.

As a courtesy to our patients, we submit to their primary and secondary insurance companies as long as the information provided to us by the patient is correct. Please remember that professional services rendered are charge to the **patient** and **not** to the insurance company. Even though an insurance claim is filed, you will still receive a statement each month if your account has a balance. This office will not accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

Please be aware that contractual adjustment will only be deducted for insurance companies that this office has a contract with. If we are not a participating provider no contractual adjustment will be made.

Full payment is expected at the time services are rendered, unless credit arrangements have been set up in advance (please ask to speak to the Office Manager). Health insurance is a contract between you and your insurance company and does not create a credit in this office. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, and secondary insurance ect. other than to supply factual information as necessary.

FINANCE CHARGES

If for some reason we allow you to have a balance with us, at our discretion, there will be a 1.50% interest charge per month for accounts over 60 days.

By signing this policy you agree that (regardless of your insurance status), you are ultimately responsible for the balance on your account. You agree to pay **ALL** fees.

_____ _____

PATIENT/RESPONSIBLE PARTIES SIGNATURE **DATE**

I have received a copy of Dr. M. Terry Jeppson's privacy policy.

_____ _____

PATIENT/RESPONSIBLE PARTY SIGNATURE **DATE**