

Patient Information **PRINT CLEARLY**

Patient Name: _____ Birth Date: _____ Sex: M ___ F ___

Address: _____ City: _____ ST: _____ Zip: _____

Home Phone #: _____ Cell #: _____ SS#: _____

Employer: _____ Phone #: _____ Hotel/Room#: _____

PHARMACY: RYAN'S OUTSIDE PHARMACY NAME: _____ PHONE: _____

Emergency Contact: _____ Home Phone #: _____
(Not living with you)

Primary Insurance Name: _____ Tele#: _____

Name of Insured: _____ Relation: _____ DOB: _____ SS#: _____

Secondary Insurance Name: _____ Tele#: _____

Name of Insured: _____ Relation: _____ DOB: _____ SS#: _____

Harmon Medical Center will make every effort to bill all available insurance for you with the condition that the complete and correct information has been provided by you at the time of the initial visit. If all insurance is not disclosed at the time of the initial visit then you waive the right to use any available medical and/or health insurance for service provider to you.

I certify the above information is true and correct to the best of my knowledge. I will notify office of any changes in health status of the above information. I hereby authorize my insurance benefits be paid directly to the physician and I understand that I am financially responsible for any/all non-covered services. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees, interest attorney fees and court cost that may be added to my account in order to recover monies due to Harmon Medical Center. I also authorize the physician and/or the insurance/s to release any and all information required in processing my claims.

I have received a copy of the office policies and the clinic policy on HIPAA.

Patient/Guardian Signature _____ Date _____

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