

ACTION PM&R and Metabolic Management Center

Patient Information Form

Patient Name: (Last) _____ (First) _____ (MI) _____

Visit Date: _____

Name you prefer to be called: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cellular: _____

Patient's E-mail Address: _____

Date of Birth: _____ Age: _____ Sex: M F

Social Security: _____ Drivers License: _____

Country of Birth: _____ Country of Parents' Birth: _____

Referred by: _____ **Address:** _____

Phone: _____ Fax: _____

Insurance Information:

Name of Person Insured: _____ Insured's Date of Birth: _____

Insured Social Security #: _____ Employer's Name: _____

Name of Insurance company and address: _____

_____ Telephone #:

Policy #: _____ Group #: _____

Release of Information: I authorize any treatment deemed necessary by Action Physical Medicine & Rehabilitation. I also authorize the release of any information necessary to process my claim.

_____ Date: _____

Signature of insured/authorized person

Assignment of Benefits: I authorize payment of benefits to Action Physical Medicine & Rehabilitation for ALL services rendered. I understand that I may be responsible for any balance NOT covered by my insurance company.

_____ Date: _____

Signature of insured/authorized person

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Employment Information:

Patient Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work phone No: _____ Ext. _____

In Case of Emergency:

Name: _____ Relationship: _____ Phone: _____

Patient's Spouse: _____ Phone: _____

Physicians:

Primary Care Physician (PCP): _____

Address: _____

Phone: _____ Fax: _____

Other Physician and Specialty (i.e., psychiatry, neurology, endocrinology)

Address: _____

Phone: _____ Fax: _____

Other Physician and Specialty (i.e., psychiatry, neurology, endocrinology)

Address: _____

Phone: _____ Fax: _____

Financial Policy:

Thank you for selecting Dr. Mikuzis / Golden for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard and checks.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

Patient's Signature

Date