PATIENT INFORMATION FORM

Patient Name: _____ Sex: ☐ M ☐ F Today's Date: _____

Last First Middle Date of Birth: _____

Years of Education: _____ HS Diploma=12; BA/BS=16; MA/MS=18; Ph.D=20 Handedness: ☐Right ☐Left ☐Ambidextrous

Marital Status: ☐ Single ☐ Single w/ Partner ☐ Divorced Chronological Age: _____

☐ Married ☐ Separated ☐ Widowed SSN: _____-_____-_____

Ethnic Origin: ☐ Asian ☐ Caucasian ☐ African American ☐ Latino ☐ Other (specify): _____

Address: _____

Street City State/Zip

Home Phone: _____ Cell Phone: _____

Referred by: ☐ Dr. _____ ☐ Friend ☐ Family ☐ Website ☐ Other: _____

Occupation: _____ Employer: _____ Employer's Phone Number: _____

Spouse/Partner's name: _____ Email Address: _____

INSURANCE INFORMATION

(Please attach copy of front and back side of insurance card)

Please fill out form completely. If incomplete, claims will not be processed and insured will be responsible for all charges.

Person responsible for bill: _____ DOB:_____ Home Phone: _____

Address: _____

Street City State/Zip

Please indicate primary insurance: _____

Insurance Address: _____

Street City State/Zip

Insured/Subscriber Name: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Date of Birth: _____ Insured SSN: _____-_____-_____

Insured Employer: _____ Insurance Phone Number: _____

ID#: _____ Group #: _____ Effective Date: _____

Please indicate secondary insurance (if applicable): _____

Insured/Subscriber Name: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

ID#: _____ Group #: _____ Effective Date: _____

Secondary Insurance Address:_____

Street City State/Zip

Secondary Insurance Subscriber Name: _____ Second Insurance Phone Number: _____

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ insurance company(ies) and assign directly to Dr. Rakic and/or her representative(s) all insurance benefits and/or payments for services rendered with my knowledge and agreement. When provided with the necessary insurance company information, Dr. Rakic and/or her representative will make efforts to secure preapproval/certification/authorization, and determine the amount that will be covered by my medical benefits prior to services being rendered. However, I do understand that certain insurance companies may decline to pay even with prior authorization. I am cognizant and agree that if that situation were to arise, I will be financially responsible for all the charges. I hereby authorize Dr. Rakic and/or her representatives to release all information necessary to process my claims.

_____ _____ _____

Relationship to Patient Signature of Responsible Party Date

Note: Please contact North Bay Medical Billing for all billing and payment questions. Phone: (800) 501-5085 Fax: (888) 706-4141

EMERGENCY CONTACT

Name of local friend or relative (not living at same address): _____

Relationship to Patient: _____ Home Phone: _____ Work Phone: _____

OFFICE POLICIES

Telephone Consultations

I understand that telephone consultations are not covered by Medicare and other health plans. Therefore, I understand that telephone contacts beyond appointment scheduling may result in a charge equivalent of $150.00 per hour for the duration of the call.

Confidentiality

I understand that my records are confidential and will not be released to outside individuals of agencies without written consent. However, certain information may be released without my authorization under the following circumstances:

- In the event of a medical emergency.
- If there is evidence of child abuse (including accessing exploitative media of minors), dependent, or elder abuse.
- When a hazard to the public requires disclosure.
- When there is an indication that I will likely harm myself or others.

Cancellation

Appointments are regarded as a contract for the exclusive use of the doctor's time. I understand that regular charges may be applied to missed appointments without 24 hours advance cancellation notice. I understand that my insurance carrier will not pay for my absence and I will be responsible for these charges.

The establishment of an account by providing your credit card information is required prior to the evaluation. If the statement sent to you is not paid within 30 days, <u>then and only then</u>, will your credit card be automatically charged with the outstanding balance. If you do not have a credit card to establish an account with us full payment will be due at the time of service, unless previous financial arrangements were agreed upon with your Provider.

I AUTHORIZE MY CREDIT CARD TO BE BILLED FOR ANY AND ALL OUT-OF-POCKET CHARGES THAT MAY BE INCURRED.

VISA/MASTERCARD (Circle One): _____ Expiration: _____ Security Code: _____

Billing Address: _____

Street City State/Zip

Signature: _____ Date: _____

(I understand my financial and business agreements)