



**NEW PATIENT INFORMATION**

<b>DATE:</b>		<b>REFERRING PHYSICIAN:</b>					
<b>PATIENT DATA</b>	PATIENT'S LEGAL NAME (LAST, FIRST, MIDDLE)			MARITAL STATUS (Circle One)		PREVIOUS NAME	
				M S W D		EMAIL ADDRESS	
	STREET ADDRESS		P.O. BOX	SEX	AGE	DATE OF BIRTH	SOCIAL SECURITY NO.
						/ /	
	CITY	STATE	ZIP CODE	PATIENT'S TELEPHONE NO.		PATIENT'S WORK TELEPHONE NO.	
				Home:			
			Cell:				
EMPLOYED BY	EMPLOYER'S ADDRESS			PATIENT EMPLOYMENT STATUS - CIRCLE ONE			
					Full Time      Active Military      Self		
PREVIOUSLY TREATED HERE	YES	NO	IT IS OKAY TO GIVE MY MEDICAL INFORMATION TO:				
YEAR							
					Part Time      Retired      Not		
					Date: / /		
NEAREST RELATIVE NAME		ADDRESS			TELEPHONE NO.		
<b>EMERGENCY CONTACT</b>	NAME		RELATIONSHIP			TELEPHONE NO.	
						CELL:	
ADDRESS		STREET	CITY		STATE	ZIP CODE	
<b>PHOLLICDER</b>	PERSON RESPONSIBLE FOR BILL		ADDRESS		CITY	STATE	ZIP CODE
	TELEPHONE NO.	RELATIONSHIP	DATE OF BIRTH	EMPLOYER	SOCIAL SECURITY NO.		
			/ /				
EMPLOYER'S NAME		ADDRESS		STREET	CITY	STATE	TELEPHONE NO.
							CELL:
<b>INSURANCE INFORMATION</b>	<b>PRIMARY INSURANCE COMPANY NAME:</b>						
	POLICY HOLDER:						
	<b>SECONDARY INSURANCE COMPANY NAME:</b>						
	POLICY HOLDER:						
<b>PLEASE BRING INSURANCE CARDS AND DRIVERS LICENSE OR OTHER FORM OF ID WITH YOU TO YOUR APPOINTMENT.</b>							

# PRE-AUTHORIZED HEALTH CARE PAYMENT AGREEMENT

I agree to pay for services as follows:

- I will pay on the day I am seen and treated
- I am eligible for Medicaid and will bring my Medicaid card to my appointment.  
My physician sponsor, clinic, plan or HMO has sent a referral form.
- We will be happy to bill your insurance for you. However, we can only bill your insurance if you provide us with your credit card. We will not bill your card unless there is an outstanding balance after 90 days. We will notify you.
- Payment plan - charge my credit card \_\_\_\_\_ each month for \_\_\_\_\_ months.
- I will pay 50% of my bill now and \_\_\_\_\_ each month for \_\_\_\_\_ months.

The Medical Procedures Center PC has my permission to charge health care fees to my

- VISA
- MasterCard
- Discover
- American Express

Patient Name \_\_\_\_\_ Signature \_\_\_\_\_

Credit Card Number \_\_\_\_\_ Exp. Date \_\_\_\_\_

## INSURANCE AUTHORIZATION

I, the undersigned, do hereby authorize The Medical Procedures Centers, P.C., to furnish to insurance companies information concerning my illness and treatments and I hereby assign benefits to the physician for all medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance or participation agreements and I am responsible to obtain any second opinions or referral slips to enhance billing. A photocopy of this agreement is to be considered as valid as an original. If you are under 18 years of age, please have a parent or guardian sign.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_ Relationship \_\_\_\_\_

## MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by this provider. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services. In the event that a service is not a covered benefit for Medicare, I agree to pay for services rendered.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_ Relationship \_\_\_\_\_

**WE PARTICIPATE WITH BLUE CROSS/BLUE SHIELD OF MICHIGAN, HEALTH PLUS, MEDICARE, DOW, DOW CORNING, CONNECT CARE AND MEDICAID. WE WILL SEND IN YOUR BILL FOR YOU. ALL PATIENTS ARE RESPONSIBLE FOR DEDUCTIBLES, CO-PAYS, AND "NON-COVERED" SERVICES, REGARDLESS OF INSURANCE. THE PATHOLOGY LAB AT THE HOSPITAL WILL BILL YOU OR YOUR INSURANCE FOR ANY SPECIMENS SENT TO THEM FOR EVALUATION.**