

Account Number

PATIENT INFORMATION

Form with fields: Last Name, First Name, Middle Initial, Street Address, City/State, Zip Code, Home Telephone, Emergency Telephone, Emergency Contact, Social Security Number, Date of Birth, Sex, Single/Married/Divorced/Widowed, Preferred Provider, Preferred Pharmacy, School Name, Date of Accident, Employer, Employer Address, Do You Have a Living Will?

RESPONSIBLE PARTY/BILLING INFORMATION

Form with fields: Last Name, First Name, Middle Initial, Street Address, City/State, Zip Code, Home Telephone, Employer Phone, Employer, Employer Address, Social Security Number

PRIMARY INSURANCE INFORMATION

Form with fields: Name of Company, Office Co-Pay, Insurance Telephone, Group Number, Policy Number, Insurance Address, City/State, Zip Code, Insured's Name, Date of Birth, Relationship, Social Security Number, Insured's Employer, Address/State/Zip Code, Telephone

SECONDARY INSURANCE INFORMATION

Form with fields: Name of Company, Insurance Telephone, Group Number, Policy Number, Insurance Address, City/State, Zip Code, Insured's Name, Date of Birth, Relationship, Social Security Number, Insured's Employer, Address/State/Zip Code, Telephone

PATIENT AUTHORIZATION

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to LMG, PC, or any of its affiliates or agents, lenders, or any third party servicer acting for LMG, PC, or any of its affiliates. I agree to promptly pay for services rendered for me or the patient named above. If I fail to meet my financial commitment to LMG and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees. I further agree to pay for any missed appointments of which I did not notify the medical office within a reasonable amount of time. I authorize LMG to test my blood for hepatitis and/or the AIDS virus, if in their opinion, an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

Signature

Date

How did you hear about our Medical Center? [ ] Yellow Pages [ ] Referral Service [ ] Physician [ ] Emergency Room [ ] Welcome Packet [ ] Family/Friend [ ] Hotel [ ] Employee [ ] Health Fair/Trade Show [ ] Direct Mail [ ] Managed Care Plan/Insurance Company [ ] Newspaper [ ] Other