PATIENT INFORMATION #3

Date _____ Referred By _____

Name _____ Home Phone _____

Cell Phone _____

Age _____ Birth Date _____ Marital Status _____ Social Security# _____

Address _____ Apt # _____ City _____ State _____ Zip _____

Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Policy Holder _____ Birth Date _____

Occupation _____ Social Security# _____

Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

In Case of Emergency Contact _____ Relationship _____

Phone _____ Second Contact if same as Home Number _____

Relationship _____ Phone _____

INSURANCE INFORMATION

Insurance Company's Name _____ Policy Holder _____

Policy ID # _____ Group # _____ Effective Date _____ Phone _____

Amount of Deductible $ _____ Has Deductible been met this Calendar Year? _____

Is There a Co-Payment with Your Plan? _____ How Much? _____

Claims Address _____ City _____ State _____ Zip _____

leave blank

SECONDARY INSURANCE

Insurance Company's Name _____ Policy Holder _____

Policy ID # _____ Group # _____ Effective Date _____ Phone _____

Amount of Deductible $ _____ Has Deductible been met this Calendar Year? _____

Claims Address _____ City _____ State _____ Zip _____

I hereby authorize Joseph C. Lindstrom, M.D. to furnish to the above insurance company(s) all medical information necessary to process any appropriate claim.

I also authorize payment of medical benefits to Joseph C. Lindstrom, M.D.. I accept responsibility for all my accrued charges including those charges which my insurance company may or may not cover at the level anticipated. Additionally, I understand that should my insurance company delay payment, I will be billed and be responsible for the entire balance.

Past due accounts over 60 days from the date of service are subject to interest charges of 1.5% per month. In the unfortunate event that an account is given to a collection agency or to an attorney for collection, then patient/responsible party shall pay to Joseph C. Lindstrom, M.D. all costs of collection, including reasonable attorney's fees and court costs, in addition to other amounts due.

I have read this information and agree with this policy.

OUR OFFICE POLICY STATES THAT PAYMENT FOR SERVICES IS REQUIRED AT TIME OF VISIT.

Advance Directives Discussed Yes No

If a referral is required and you fail to bring one, you will be responsible for the bill.

_____
PATIENT'S SIGNATURE

_____
PARENT/GUARDIAN

_____
DATE