Kathy Plesser, MD, PLLC

WELCOME TO OUR OFFICE

PATIENT INFORMATION **ACCOUNT#_____** **DATE_____**

_____ _____ _____
(LAST NAME) (FIRST NAME) (MIDDLE)

AGE: _____ DATE OF BIRTH ____/____/_____ SOCIAL SECURITY # _____-_____-_____

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE # (_____) _____-_____ CELL PHONE # (_____) _____-_____

PATIENT'S EMPLOYER: _____ WORK PHONE # (_____) _____-_____

SPOUSE/OTHER: _____ DAYTIME PHONE # (_____) _____-_____
(NAME)

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REFERRING MD_____PHONE # (_____) _____-_____

FAX # (_____) _____-_____

IS THERE ANOTHER MD WHO SHOULD RECEIVE YOUR REPORT(S)?

*NAME_____PHONE # (_____) _____-_____

ADDRESS:_____CITY/STATE/ZIP_____

*NAME_____PHONE # (_____) _____-_____

ADDRESS:_____CITY/STATE/ZIP_____

*NAME_____PHONE # (_____) _____-_____

ADDRESS:_____CITY/STATE/ZIP_____

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INSURANCE INFORMATION

PRIMARY INSURANCE **NAME OF POLICY HOLDER** **POLICY#/GROUP#**

_____ _____ _____

MEDICARE NUMBER_____ EFFECTIVE DATE _____

SECONDARY INSURANCE **NAME OF POLICY HOLDER** **POLICY#/GROUP#**

_____ _____ _____

PERSON RESPONSIBLE FOR PAYMENT, IF OTHER THAN SELF (GUARANTOR INFORMATION):

GUARANTOR'S NAME_____ RELATIONSHIP_____

SOCIAL SECURITY NUMBER _____-_____-_____ DATE OF BIRTH _____/_____/_____

ADDRESS_____CITY/STATE/ZIP_____

REMARKS: PLEASE ANSWER ALL THE QUESTIONS AND SIGN THE BACK PAGE. THANK YOU.

Dear Patient:

This letter is a confirmation of your responsibility to pay all deductibles and all non-covered procedures pertaining to your assignment.

Any checks that have inadvertently been sent to you for procedures done in this office must be endorsed by you and forwarded to us with the explanation of benefits.

Authorization of Release to Insurance Company:

I authorize any holder of medical or other information about me to release to my insurance company, its intermediaries or carriers any information needed for this or any related insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who is accepting assignment of benefits.

I have read and agree with the above requirements.

Signature_____ Date_____

Medicare: (for Medicare patients only)

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare & Medicaid Services (CMS), its intermediaries or carriers any information needed for this or any related Medicare claim. I permit a copy of this claim to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignments of benefits apply.

I have read and agree with the above requirements.

Medicare Number_____

Signature_____ Date_____

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For Internal Use Only

I attempted to obtain patient acknowledgement but was unable to do so for the reason set forth below:

Date:_____ Staff initials_____