



Patient Information

Name: \_\_\_\_\_ Sex: M or F Martial Status: S M D W

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, And Zip: \_\_\_\_\_

Home#: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_

Driver License#: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Referring Physician Office #: \_\_\_\_\_

Purpose of Appointment: \_\_\_\_\_

What medications/drugs are you taking? \_\_\_\_\_

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Name of Primary Insurance Company: \_\_\_\_\_

**Authorization and Release:** I authorize payment of insurance benefits directly to Dr. Bond. I authorize the doctor to release all information necessary to communicate with personal physician and other healthcare providers and payers and to secure the payment benefits. I understand that I am responsible for all cost regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fee for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16 percent.

The patient understands and agrees to allow the Doctor's office to use their Patient Health Information for the purpose of treatment payment, healthcare operations and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing consent. If there is anyone you do want to receive your medical records, please inform our office.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

