PATIENT INFORMATION SHEET

Confidential Patient Information

Acct #: _____

Please Print

MSG DDG

Name: _____
Legal First M. Last

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Email Address: _____ How were you informed of our services? _____

Age: _____ Date of Birth: _____ Sex: ☐ M ☐ F Marital Status: ☐ M ☐ S ☐ W ☐ D

Spouse (*Parent if student or minor*): _____ Cell Phone: _____

Spouse/Parent's Employer: _____ Work Phone: _____

Parent's Address (*If student or minor*): _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Person responsible for payment of this account: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

☐ **Primary Coverage:**

Ins. Company: _____ ID# _____

Name of Insured: _____ **Birthdate** _____

Employer: _____ Group# _____

☐ **Secondary Coverage:**

Ins. Company: _____ ID# _____

Name of Insured: _____ **Birthdate** _____

Employer: _____ Group# _____

☐ **No Insurance Coverage**

Please provide a copy of your insurance card OR complete the information at the left

If I do have insurance that may provide benefit toward my account, it is my understanding that the Advanced Care Center will submit my charges to the designated company (unless other arrangements are made). I understand that my insurance policy is a contract between my insurance company and myself; the Advanced Care Center CANNOT guarantee benefits. I request the Advanced Care Center to complete any usual and customary reports and/or forms to assist in collecting from my insurance company. I agree to pay all co-pay and deductible amounts at the time of service. I agree that if I choose to suspend or terminate my scheduled treatment with the Advanced Care Center or if for any reason my charges are not paid by insurance, *I am immediately responsible for full payment of all charges on my account.*

If I do not have insurance coverage, I agree to pay for my services in full at the time of service, unless I have made other arrangements with the Advanced Care Center. If for any reason timely payment is not received on my account, I am responsible for and agree to pay the monthly handling fee until the account is paid in full.

I understand the above information was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to the information provided on this form or any changes in my medical status.

Patient's Signature: _____ Date: _____

Guardian's Signature: (*Authorizing Care:*) _____ Date: _____

Office Use Only: ☐ Informed ☐ HIPAA ☐ Mark ☐ E-mail ☐ Party _____

Revised 1/15