DEMOGRAPHIC & INSURANCE INFORMATION

ASSIGNMENT OF BENEFITS; RELEASE OF INFORMATION
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Today's Date: _____

Patient Name: _____ _____
Last First
Date of Birth: _____/_____/_____ Male:_____ Female: ____
Month/Day/Year

Last Four of S.S. #_____

Telephones: Home:_____Cell: _____Other: _____

Address: _____ Zip: _____

Email: _____

Primary Physician:_____ Tel: _____ Fax: _____

Pharmacy Name: _____ Phone: _____

Insurance Carrier: _____ID Number: _____ COPAY_____
Guarantor Name: _____ Relationship: _____
Date of Birth:_____
Do You Have A Secondary Insurance? Yes____ No____ Initial_____

Please acknowledge the following the statements by INITIALING on each line.

1. All co-pays and deductibles are due prior to treatment. _____
2. If your insurance or other pertinent personal information changes, please notify us as soon as possible. _____
3. For insurances we participate with, we will accept assignment of insurance benefits._____
4. I hereby agree to accept full financial responsibility for the vaccines which are non-covered based on my current insurance benefits. _____
5. Payment for Excluded Services is due on day of service. _____
6. Payment for telephone consults is due at time of service _____
7. We cannot provide medical services to minor patients without the presence of their parent or legal guardian without written notice. _____
8. Please help us serve you better by keeping scheduled appointments. Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments. _____

I/We acknowledge and agree that I/We have received a copy of Dr. Mavunda's Notice of Privacy Practices
I/We hereby authorize payment directly to Dr. Mavunda for all insurance benefits payable for professional services rendered
I/We authorize Dr. Mavunda and her staff to release requested information for payment of benefits, and to use the signature(s) below on all insurance submissions.
I/We certify this information is true and correct.

Name & Signature: _____