

SECTION 1: PATIENT INFORMATION

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  Over 18 years

Address: \_\_\_\_\_  
\_\_\_\_\_

Social Security #: \_\_\_\_\_

Sex:  Male  Female

Email Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

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

Marital Status: (check one)  Single  Married  Other Spouse Name: \_\_\_\_\_ Spouse Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

SECTION 2: GUARANTOR INFORMATION (Person Responsible for payments)

Self (If you checked self, skip down to Section 3)

Insured's Name: \_\_\_\_\_  
(If different from patient)

Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

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

Employer Phone: \_\_\_\_\_

SECTION 3: INSURANCE INFORMATION

Primary Insurance:

Secondary Insurance:

Name of Insurance: \_\_\_\_\_

Name of Insurance: \_\_\_\_\_

Group #: \_\_\_\_\_

Group #: \_\_\_\_\_

Effective Start Date: \_\_\_\_\_

Effective Start Date: \_\_\_\_\_

Member #: \_\_\_\_\_

Member #: \_\_\_\_\_

Patient is the subscriber (If you checked here, skip down to Section 3-A)

Patient is the subscriber (If you checked here, skip down to Section 3-A)

Subscriber's Soc. Sec # \_\_\_\_\_

Subscriber's Soc. Sec # \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Birth Date of Subscriber: \_\_\_\_\_

Birth Date of Subscriber: \_\_\_\_\_

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

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

Patient's Relationship to Subscriber: (Check one)  Spouse  Child  Other \_\_\_\_\_

SECTION 3-A: Assignment of Benefits Authorization

I request that payment be made on my behalf, to Bull Run Family Practice, P.C. for any covered services furnished me. I also authorize release of medical information relevant to these services when required by Health Care Financing Administration (HCFA), its agents or insurance carriers, including and/or Medigap insurer indicated above, for determining eligibility of benefits in accordance with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

SECTION 4: RELEASE AUTHORIZATION:

Medical information and prescriptions for the patient listed on this document may be released to:  Left on answering machine

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
List Name of Authorized Person List Name of Authorized Person

SECTION 5: COLLECTION POLICY

In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect this amount or any future outstanding account balances. I understand that an additional service charge of \$15.00 may be incurred when co-payments are not made at the time of service. A one-time charge of \$5 will be added to cover the cost of billing patient account balances exceeding 60 days from the date of your statement. Patient account balances exceeding 90 days from statement date are subject to interest charges of 1% per month.

Cancellations are requested 24 hours prior to the appointment. There will be a \$50.00 fee for missed or late-cancelled appointments. Should you miss two appointments and fail to cancel in advance, you will be charged a \$100 fee for the next time you miss an appointment and you may be discharged from the Practice. There is a \$30.00 fee for all returned checks.

I understand that failure to keep this account current may result in Bull Run Family Practice being unable to provide additional services, except for emergencies. Bull Run Family Practice will notify me in writing, in advance, should this become necessary.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness