BELOIT MEDICAL CENTER, P.A.

PATIENT INFORMATION

With whom may we discuss your: DATE: _____ /_____ /__________

Healthcare? *(circle all that apply)* Spouse Children Parents Step Parents Other (______________)

Billing Info? *(circle all that apply)* Spouse Children Parents Step Parents Other (______________)

• PLEASE PRINT INFORMATION LEGIBLY •

PATIENT'S NAME: ____

PATIENT'S ADDRESS: ____

CITY: ________________________________ STATE: ___________ ZIP: ____________________

DATE OF BIRTH: _____ /_____ /__________ SEX: M F SOC. SEC. NO.: _______ - _____ - __________

PATIENT'S PRIMARY CONTACT TELEPHONE NO.: _________ - _________ - ______________

EMPLOYER: ___________________________________ TELEPHONE NO.: _________ - _________ - ______________

EMPLOYER'S ADDRESS : ____

SPOUSE'S EMPLOYER & ADDRESS: ____

NEAREST FRIEND OR RELATIVE NOT RESIDING WITH YOU: ____

INSURANCE INFORMATION: PRIMARY: ____

SECONDARY: ____

☐ NONE

A finance charge of 1.5 percent per month will be added to past due balances on your accounts (after payment of insurance benefits) if not padi by the 25th of the following month.

The patient or responsible party agrees to pay all reasonable costs of collection, including, but not limited to, court costs, attorney fees and collection agency fees, except that such costs of collection: ***(1)*** *may not include costs incurred by a salaried employee of the creditor or its assignee:* ***(2)*** *may not include the recovery of both attorney fees and collection agency fees; and* ***(3)*** *shall not be in excess of 18% of the unpaid debt after default.*

SIGNATURE: ____ DATE: _____ /_____ /__________

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees regardless of insurance coverage.
It is customary to pay for services when rendered unless other arrangements have been made in advance.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize BELOIT MEDICAL CENTER, P.A. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the phsycian(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

SIGNATURE: ____ DATE: _____ /_____ /__________