WELCOME TO OUR OFFICE

Included you will find the forms required for your first visit. Please complete the forms in their entirety, prior to your appointment, using a black pen. Please do not date any of the forms. We will complete the date when you arrive for your appointment.

If the appointment is for a minor, all forms must be completed by a parent or guardian and must include the patient’s name and the parent’s or guardian’s signature. If you are the guardian, it is important that you bring the court ordered paperwork with you for the minor’s first visit.

We have included specific instructions for each form in your packet to assist you in completing this necessary information.

Please remember to bring your completed forms, a photo id and insurance cards to your appointment. We look forward to your visit and helping you with your health concerns.

If you have any questions regarding the completion of these forms, please contact our office and we will be happy to assist you.

Entrance Application
This form provides us with your personal information required to complete your registration as a new patient in our office. Please be sure to fill out the form as complete as possible.

Financial Agreement
This form informs you of your financial responsibility for your treatment in our office and gives us permission to file your insurance and receive benefit payments directly from your insurance company. Please sign this form in both places. Do not date the form.
Entrance Application

We are honored you chose us to evaluate your health. To better serve you, please fill out the personal information below. If you need assistance, please inform our front desk team member. Thank you and welcome to HealthSource!

Patient Information
First Name: __________________ Middle _______________ Last _________________ Gender: __M __ F
Address: __________________________________________________________________________________
City: ________________ State: ___________ Zip Code: ______________
Home Phone: ___________________________ Cell Phone: ___________________________
Email Address: ___________________________ Birthdate: ______________ Age: _____
Marital Status: ___ S ___ M ___ W ___ D  Job Title: ___________________________ Work Phone: _______________
Spouse Name: ___________________________ Birthdate: ___________________________
Children: Names and Ages: ____________________________________________________________________

Insurance Information
Name of person on the insurance card: _______________________________ DOB: ______________
Name of employer: __________________________________________________________________________
Employer phone number: ___________________________ City: _____________________________
Person responsible for this account: ________________________________

Additional Information
In case of emergency, whom should we contact? ________________________________
Relation to patient: ___________________________ Phone Number: ___________________________
Family Physician: __________________________________________________________________________
May we send your Family Physician updates on your progress? ________ Yes ________ No

What is your primary complaint? ___________________________

Is this worker’s compensation? ________________ Is this personal injury? _______________________

Office use only  Account Number  Date

Entrance App 10.24.18
Financial Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSITUTE FOR PAYMENT. Some companies pay fixed amounts for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLES AT THE TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, HealthSource shall be entitled to reasonable attorney’s fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

PATIENT’S/GUARDIAN’S SIGNATURE  INSURED’S SIGNATURE

INSURANCE COMPANY NAME  DATE

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee healthcare benefits coverage with the above captioned, and hereby assign and convey directly to HealthSource all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize any plan administrator or fiduciary, insurer or my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee healthcare plan any claim, chose in action, or other right I may have to such insurance and/or employee healthcare benefits coverage under any applicable insurance policies and/or employee healthcare plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim chose in action or right against my insurers and/or employee healthcare plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee healthcare plan in my name but at such doctor and clinic’s expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered and valid as the original. I have read and fully understand this agreement.

PATIENT’S/GUARDIAN’S SIGNATURE  DATE