MINOR PATIENT INFORMATION SHEET

Patient Name _____ Sex: M: ___ F:___
LAST FIRST MIDDLE

Address _____

City _____ State _____ Zip _____

Student? _____ Full-Time _____ Part-Time _____

School _____

Home Phone _____

Date of Birth:_____ SS# _____

PARENT OR GUARDIAN INFORMATION

Father's Name _____

Address _____

City, State, Zip _____

Date of Birth_____ SS# _____

Home Phone _____

Place of Employment _____

Work Phone _____

Mother's Name _____

Address _____

City, State, Zip _____

Date of Birth _____ SS# _____

Home Phone _____

Place of Employment _____

Work Phone _____

IT IS VERY IMPORTANT THAT YOU PROVIDE US WITH YOUR COMPLETE, ACCURATE, AND CURRENT INSURANCE COVERAGE. We are a participating provider with many insurance companies. As a part of our contracts we are required to file your claims to these companies. **WE MUST HAVE A COPY OF ALL INSURANCE CARDS.**

Father's Ins. Co. _____

Is this PRIMARY COVERAGE? _____

Mother's Ins. Co. _____

Is this PRIMARY COVERAGE? _____

Is this patient covered under any **other** insurance?

Insured Name _____

SS#_____ DOB _____

Employer _____

Phone # _____

Relationship to patient _____

Insurance Co. _____

(OVER)

NO INSURANCE
I do not have insurance coverage. I will not file to any insurance company for reimbursement. I understand that I am responsible for my bill at the time of service. We accept American Express, MasterCard, Visa and Discover.

Patient's Signature _____ Date_____

MANAGED CARE INSURANCE & MEDICARE
If we are a participating provider with your insurance company you are responsible for any allowable copayment and/or deductible.
I authorize Robert M. Rogers, M.D., P.A. to release to my insurance companies any information required for service provided. I permit a copy of the authorization to be used in place of the original and request that payment of insurance benefits be assigned to Robert M. Rogers, M.D., P.A.
I agree to pay all copays, deductibles and balance of allowable fees.

Patient's Signature _____ Date_____

ALL OTHER INSURANCE
As a professional courtesy we will file insurance for surgical procedures only. We cannot assume responsibility of your payment by your insurance carrier, nor can we accept their payment as payment in full.
I understand that my insurance is a contractual agreement between myself and my insurance company. I agree to pay any amount not paid by my insurance company. I authorize Robert M. Rogers, M.D., P.A. to release to my insurance companies any information required for services provided. I permit a copy of the authorization to be used in place of the original and request that payment of insurance benefits be assigned to Robert M. Rogers, M.D., P.A.

Patient's Signature _____ Date_____

FOR PATIENT SERVICES REFERRED FOR LABOR PATHOLOGY SERVICES
I authorize Robert M. Rogers, M.D., P.A. to forward my insurance information to such labs. I authorize Dermatology Consultation Service, LabCorp, Quest, Pathology Consultants or SmithKline Beecham to release to my insurance companies any information required for services provided. I permit a copy of this authorization to be used in place of the original and request that payment of insurance benefits be assigned to them.

Patient's Signature _____ Date_____

We send out patient statements at the beginning of each month. A service charge of 1 1/2% monthly (18% APR) is added to accounts not paid in full by the last day of the month. Patients with managed care insurance are billed after insurance processes their claim.

ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES
Robert M. Rogers, M.D., P.A. ***Notice of Privacy Practices*** **has been provided to me for my review. I understand that the purpose of this notice is to inform me of my rights in regard to my Protected Health Information and also the ways in which** Robert M. Rogers, M.D., P.A. **may use my Protected Health Information.**

Patient's Signature _____ Date_____