PATIENT INFORMATION SHEET

DATE: _____ ACCT#: _____

PATIENT'S NAME: _____
(AS IT APPEARS ON CARD) LAST FIRST MIDDLE

SSN: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DOB: ____/____/____ AGE: _____ SEX: _____

MARITAL STATUS: SINGLE: _____ MARRIED: _____ WIDOWED: _____ DIVORCED: _____

ARE YOU EMPLOYED? _____ FULL TIME: _____ PART TIME: _____

ARE YOU RETIRED? _____ DATE OF RETIREMENT: _____

HOME TELEPHONE NUMBER: _____ CELL NUMBER: _____

SPOUSE'S NAME: _____

DOB: ____/____/____ SSN: _____

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. If you have insurance through your employer that insurance is primary and must be filed first. Insurance through your spouse's employer is secondary and will be filed after we hear from the primary insurance. WE MUST HAVE A COPY OF ALL INSURANCE CARDS.

PATIENT'S PLACE OF EMPLOYMENT: _____ TELEPHONE NUMBER: _____

SPOUSE'S PLACE OF EMPLOYMENT: _____ TELEPHONE NUMBER: _____

PRIMARY INSURANCE COVERAGE: _____ ID / POLICY #: _____

GROUP #: _____

SUBSCRIBER NAME AS IT APPEARS ON CARD: _____

SUBSCRIBER DOB: ____/____/____ SUBSCRIBER RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE COVERAGE: _____ ID / POLICY #: _____

GROUP #: _____

SUBSCRIBER NAME AS IT APPEARS ON CARD: _____

SUBSCRIBER DOB: ____/____/____ SUBSCRIBER RELATIONSHIP TO PATIENT: _____

PERSON TO CONTACT IN CASE OF EMERGENCY: NAME: _____

RELATIONSHIP TO PATIENT: _____ PHONE: _____

HOW DID YOU CHOOSE US? INTERNET___ PHONEBOOK___ REFERRED BY FRIEND/FAMILY___ PHYSICIAN/DOCTOR___ OTHER_____

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_____