RHEUMATOLOGY & OSTEOPOROSIS CENTER OF MEMPHIS, P.C.
PATIENT INFORMATION

Please Print
PATIENT INFORMATION

Date: _____

Patient's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: _____ Date of Birth: _____ Age: _____ Phone: _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced Social Security # _____

Employer: _____ Work Phone: _____

Employer's Address: _____

Method of Payment: ❑ Cash/Check ❑ Credit Card ❑ Other

INSURANCE INFORMATION

Primary Insurance Company: _____

Address: _____

Insured Name: _____ Date of Birth: _____ Relationship: _____

Policy Number: _____ Group Number: _____

Employer Name and Address: _____

SECONDARY INSURANCE COMPANY _____

Address: _____

Insured Name: _____ Date of Birth: _____ Relationship: _____

Policy Number: _____ Group Number:

Employer Name and Address: _____

REFERRING DOCTOR _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Patient's Nearest Relative: _____ Relationship: _____
(Not Living with Patient)

Address: _____ Phone: _____

Emergency Notification: _____ Relationship: _____

Address: _____ Phone: _____

PLEASE READ AND SIGN THE BACK SIDE OF THIS PAGE

AS A COURTESY TO YOU, WE WILL BE HAPPY TO FILE YOUR INSURANCE FOR YOU. PAYMENT FOR SERVICES RENDERED TO YOU, HOWEVER, IS ULTIMATELY THE RESPONSIBILITY OF THE PATIENT AND NOT CONTINGENT UPON THE INSURANCE SETTLEMENT.

–PLEASE NOTE–

IF YOUR INSURANCE REQUIRES A "REFERRAL", IT IS YOUR RESPONSIBILITY TO EITHER HAVE THAT REFERRAL SENT TO THIS OFFICE BY YOUR PRIMARY CARE PHYSICIAN, PRIOR TO YOUR VISIT, OR BRING IT WITH YOU AT THE TIME YOU ARRIVE FOR YOUR SCHEDULED APPOINTMENT. IF WE DO NOT HAVE THE "REFERRAL", YOU WILL BE ASKED TO RESCHEDULE YOUR APPOINTMENT, OR ASKED TO PAY ALL CHARGES INCURRED FOR THAT VISIT, IF FULL.

CONSENT FOR TREATMENT, RELEASE OF INFORMATION AND PAYMENT OF BENEFITS

I, _____ , request that payment of authorized medicare and other health insurance benefits be made either to me or on my behalf to the physician members of the Rheumatology & Osteoporosis Center of Memphis, P.C. for any services furnished me by that provider. I authorize any holder of medical information needed to determine these benefits or the benefits payable for related services.

Signed: _____ Date: _____

ACCEPTANCE OF FINANCIAL RESPONSIBILITY

I, _____ , in consideration of the medical services rendered and/or to be
(Name of Patient)

rendered, agree to The Rheumatology & Osteoporosis Center of Memphis, P.C. to accept personal responsibility for services rendered to me. If this account is placed with a collection agency, I will be responsible for all collection fees, reasonable attorney fees and any court costs incurred.

Signed: _____ Date: _____

I, _____ , authorize the Doctor to deposit checks received by the insurance company, payable on my account when made out in my name.

Signed: _____ Date: _____

CLICK TO PRINT FORM