TRINITY MEDICAL CARE, PC- PATIENT DATA

NAME_________________________________ DOB__________SOC. SEC ______-____-______
FIRST MIDDLE INITIAL LAST

ADDRESS____________________________________ CITY__________________STATE____

ZIP CODE___________HOME PHONE_____________________E-MAIL__________________

MARITAL STATUS________OCCUPATION____________EMPLOYER______________________

EMPLOYMENT ADDRESS_______________________________WORK PHONE_____________

POLICYHOLDER OF HEALTH INSURANCE (if other than self)_____________________________

DOB of POLICYHOLDER _____________ EMPLOYER_________________________________

*** KINDLY INFORM THE RECEPTIONIST IF YOU HAVE A SECONDARY INSURANCE ***

NAMES of HOUSEHOLD MEMBERS	RELATION	DATE OF BIRTH

PLEASE APPOINT SOMEONE TO NOTIFY IN CASE OF EMERGENCY:

____
NAME PHONE ADDRESS

PRESCRIPTION REFILLS WILL BE PROVIDED DURING THE OFFICE VISIT. YOU WILL BE GIVEN AN AMOUNT TO LAST UNTIL THE NEXT OFFICE VISIT. PLEASE PLAN ACCORDINGLY AND MAKE YOUR NEXT APPOINTMENT BEFORE YOU RUN OUT OF MEDICATION. WE WILL ONLY DO REFILLS WITHOUT AN OFFICE VISIT ON RARE OCCASIONS.

WE DO NOT MAIL, FAX OR PHONE IN MAIL ORDER PRESCRIPTIONS. PLEASE ASK FOR A 90 DAY SUPPLY WHILE YOU ARE IN THE OFFICE.

APPOINTMENTS THAT ARE CANCELLED WITHOUT A 24 HOUR NOTICE WILL INCUR A CHARGE OF $25.00. THE CHARGE FOR RETURNED CHECKS IS ALSO $25.00.

BILLING AGREEMENT

I ACKNOWLEDGE FULL RESPONSIBILITY FOR PAYMENT OF SERVICES RENDERED TO ME. I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO MY INSURANCE COMPANY(IES) CONCERNING ANY ILLNESS AND TREATMENT. I UNDERSTAND THAT, UNDER THE TERMS OF THE CONTRACT I HAVE WITH MY INSURANCE COMPANY, I MUST PAY ANY PRE-DETERMINED CO-PAYMENTS AT EVERY VISIT. **PLEASE BE ADVISED THAT WE PREFER PAYMENT IN CASH AND CHECKS ONLY.** IF I HAVE INSURANCE THAT TRINITY MEDICAL CARE PARTICIPATES WITH, I AUTHORIZE ASSIGNMENT OF PAYMENT DIRECTLY TO DR. LINDA GEORGE FOR MEDICAL SERVICES RENDERED TO ME. IT IS MY RESPONSIBILITY TO MAKE SURE THAT DR. GEORGE IS LISTED AS MY PRIMARY CARE DOCTOR WITH MY INSURANCE COMPANY. IF THIS IS NOT THE CASE, I WILL BE BILLED DIRECTLY AND WILL BE RESPONSIBLE FOR FULL PAYMENT. IF I AM A PATIENT WITH NO INSURANCE COVERAGE, I AGREE TO PAY MY BALANCE IN FULL AT THE TIME SERVICES ARE RENDERED.

SIGNATURE:____ DATE______________
PATIENT OR LEGAL GUARDIAN