PIEDMONT PSYCHIATRIC CLINIC

PATIENT'S INFORMATION:

_____ _____ _____
LAST NAME FIRST NAME MIDDLE NAME

STREET ADDRESS: _____ _____ CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NUMBERS: HOME: _____ CELL: _____ WORK:

_____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

MARTIAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

EMPLOYERS NAME: _____ OCCUPATION: _____

EMPLOYERS ADDRESS: _____

PATIENT'S EMERGENCY CONTACT: WHO MAY WE CONTACT IN CASE OF AN EMERGENCY? _____

WHAT IS THIS PERSON'S RELATIONSHIP TO YOU? _____

EMERGENCY CONTACT TELEPHONE NUMBERS: HOME: _____ CELL:_____ WORK: _____

FINANCIAL RESPONSIBILITY:

_____ _____ _____ _____
LAST NAME **(IF DIFFERENT from ABOVE)** FIRST NAME, MIDDLE NAME SOCIAL SECURITY: DOB:

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NUMBERS: HOME: _____ CELL: _____ WORK: _____

VISA/MASTERCARD# _____ EXP:_____ CARD HOLDER'S SIGNATURE: _____

PATIENT'S INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY: _____ INSURANCE CO. PHONE NUMBER: _____

MEMBER ID: _____ MEMBER'S GROUP #: _____ EFFECTIVE DATE: _____

PRIMARY POLICY HOLDERS NAME: _____ DATE OF BIRTH: _____ EMPLOYER: _____

ARE YOU A FULL TIME STUDENT? YES NO WHERE?
_____

INSURANCE AUTHORIZATION: I request that payment of authorized insurance company benefits be made either by me or on my behalf to Piedmont Psychiatric Clinic or its authorized agent. I authorize Piedmont Psychiatric Clinic to release services and medical information to insurance company and / or its agent needed to determine these benefits or the benefits to related services. I understand, my signature requests payment be made and authorize release of medical information necessary to pay the claim(s).

GUARANTOR-FINANCIAL RESPONSIBILITY: I understand that regardless of any insurance coverage, I am financially responsible for all charges generated by this patient/guarantor. Office policy requires payment at the time of service. Should insurance benefit assignment be accepted, any unpaid services will be paid by me within 30 days of notification. I understand that unpaid balances over 30 days past due may carry an Administrative late fee and finance charges equivalent to 1.5% of that outstanding balance. I also understand that if I do not pay my co-pay or balance for services rendered at the time of checking out then I will automatically access a $25 charge. I waive confidentiality to Attorney's, Collection Agencies, and Credit Bureau's if I do not pay my bill. I understand that I will be responsible for any and all fees that are incurred during the collection process. I also understand that my credit card will be charged for any and all late cancellations and missed appointments, unless arrangements have been made in advance with management.

PRINT PATIENT'S / GUARANTOR'S NAME: _____ DATE:_____

SIGNATURE OF PATIENT / GUARANTOR: _____ DATE: _____