|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Last Name: |  | | | | | | | | First Name: |  | | | | | | MI: |  | |
|  |  | | | | | |  | |  |  | | |  | | | |  | |
| Gender: | Male Female | | | | | | Date of Birth: | | / / | | Social Security# | | | - - | | | | |
|  |  | | | | | | | | |  | |  | | | |  |  |  |
| Referring Physician: | | | |  | | | Marital Status | | Single Married Widowed Divorced Domestic Partner | | | | | | | | | |
|  |  | | | | | |  | |  |  | |  | | | |  |  | |
| Address: |  | | | | | | | | | City: | | | | | State: |  | Zip Code: |  |
|  |  | | | | | |  | |  |  | |  | | | |  |  | |
| Telephone Numbers | | | | Primary: | | | |  | |  | | Secondary: | | | | |  | |
|  |  | | | | | |  | |  |  | |  | | | |  |  | |
| Employer’s Name: | |  | | | | | | | Occupation: |  | | Phone: | | | |  | | |
|  |  | | | | | |  | |  |  | |  | | | |  |  | |
| Race: | Asian Native Hawaiian Other Pacific Islander Black/African American | | | | | | | | | | | | | | | | | |
|  | American Indian/Alaskan Native White More than one Race Decline to answer | | | | | | | | | | | | | | | | | |
|  |  | | | | | |  | |  |  | |  | | | |  |  | |
| Ethnicity | Not Hispanic/Latino Hispanic/Latino Decline to answer | | | | | | | | | | |  | | | |  |  | |
|  |  | | | | | |  | |  |  | |  | | | |  |  | |
| Language | English Spanish Other: | | | | | | | | | E-Mail: | |  | | | | | | |
|  |  | | | | | |  | |  |  | |  | | | |  |  | |
| **Insurance** | | | | | | | | | | | | | | | | | | |
| Insurance card(s) or proof of insurance must be presented at the time of service | | | | | | | | | | | | | | | | | | |
| **Primary Insurance:** | | |  | | | | | | | | | | | | | | | |
| \*\*If you are not the policy holder, please complete the following information\*\* | | | | | | | | | | | | | | | | | | |
| Policy Holder’s Name: | | | | |  | | | | Date of Birth: |  | | Policy Number: | | | | |  | |
| **Secondary Insurance:** | | | | |  | | | | | | | | | | | | | |
| \*\*If you are not the policy holder, please complete the following information\*\* | | | | | | | | | | | | | | | | | | |
| Policy Holder’s Name: | | | | | |  | | | Date of Birth: |  | | Policy Number: | | | | |  | |
| **Assignment and Authorization of Benefits for Patients with Insurance** | | | | | | | | | | | | | | | | | | |
| I hereby state that the above information is true and correct to the best of my knowledge. I hereby assign, transfer, and set over to Fredericksburg Clinic all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance. | | | | | | | | | | | | | | | | | | |
|  |  | | | | | |  | |  |  | |  | | | |  |  | |
| Signature of Patient or Personal Representative | | | | | | | | | |  | | Date | | | | | | |
| **\*\*\*Financial acknowledgement for Private Pay Patients or Patients without Insurance\*\*\*** | | | | | | | | | | | | | | | | | | |
| Patients who do not have insurance coverage are expected to pay charges in full at the time services are rendered. I agree that I am financially responsible for all charges incurred during the time of service. | | | | | | | | | | | | | | | | | | |
|  |  | | | | | |  | |  |  | |  | | | |  |  | |
| Signature of Patient or Personal Representative | | | | | | | | | |  | | Date | | | | | | |

