

Please Print

PATIENT INFORMATION

NAME		DATE
ADDRESS	CITY	ZIP
HOME PHONE	BUSINESS PHONE	SOCIAL SEC. NO.
DATE OF BIRTH	AGE	SEX M F
REFERRED BY	PERSONAL PHYSICIAN	MARITAL S M W D SEP.
PATIENT'S EMPLOYER	BUSINESS ADDRESS	
SPOUSE'S NAME	DATE OF BIRTH	
SPOUSE'S EMPLOYER	BUSINESS ADDRESS	SPOUSE'S S.S.#

PERSON RESPONSIBLE FOR BILL (IF OTHER THAN ABOVE)

NAME	RELATIONSHIP
ADDRESS (IF OTHER THAN ABOVE)	HOME PHONE
EMPLOYER	BIRTH DATE
BUSINESS ADDRESS	BUSINESS PHONE

COMPUTER NO. _____ **INSURANCE** COVERAGE _____

MEDICARE NO. _____ MEDICAID NO. _____

BC/BS PHONE NO. _____ PRIMARY SPONSOR _____

BLUE CROSS NO. GROUP _____ SERVICE CODE _____

CONTRACT _____ SUBSCRIBER _____

MISCELLANEOUS INSURANCE

COMPANY NAME _____

ADDRESS _____

PHONE _____ SUBSCRIBER _____

GROUP NO. _____ POLICY NO. _____

AUTHORIZATIONS

BENEFITS TO PHYSICIAN AND RELEASE OF INFORMATION:

I hereby authorize payments directly to the physician of the surgical and/or medical benefits. I also understand I am responsible for any portion of my bill not covered by my insurance company. I hereby authorize release of information for insurance claim purposes. Photostat of above is as valid as the original.

SIGNED _____
Patient or Parent if Minor

NEAREST PERSON TO NOTIFY IN AN EMERGENCY

NAME	RELATIONSHIP
ADDRESS	HOME PHONE
EMPLOYER	POSITION BUSINESS PHONE

FINANCIAL POLICY FOR DAVID L. WOLF D.O.

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE

WE ACCEPT CASH, CHECKS or VISA/MASTERCARD

ALL CO-PAYS AND DEDUCTIBLES ARE DUE ON THE DAY OF TREATMENT

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients

Adult patients are responsible for full payment at time of service.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency will be denied unless charges and treatment have been pre-authorized to the approval of our office.

If your account becomes seriously past due you will no longer be able to be seen in our office until your balance is paid in full.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

X _____ Date _____
Signature of Patient or Responsible Party

X _____ Date _____
Signature of Co-Responsible Party