WELCOME TO SUNDANCE MEDICAL CENTER

Dr. Thomas Peters Dr. Justin Striblen Jessica Lucero, FNP Heather Harris, FNP

Patient Information: (please print clearly)

Patients Name_____ Date of Birth_____ Age____

Male____ Female____ Marital status_____ Social Security # _____

Home Address _____Apt #_____

City_____ State_____ Zip Code _____

Home Phone_____ Day Time/ Cell phone _____

Patients Employer_____ Occupation _____

RACE:

____American Indian or Alaska Native ____Black or African American ____ White

____ Native Hawaiian or Pacific Islander ____ Asian ____ More than one race

____ Hispanic ____Other Race ____ Do Not Wish to Provide

ETHNICITY: ____ Hispanic ____ Not Hispanic ____ Do Not Wish to Provide

PREFERRED LANGUAGE: English:_____ Other:_____

Spouse Name_____ Date of Birth_____ Age____

Male____ Female_____ Social Security # _____

Home phone_____ Day Time/ Cell Phone_____

Spouse Employer_____ Occupation_____

Parent / Responsible Party (if patient is a minor)

Name_____ Date Of Birth_____

Employer_____ Social Security#_____

Home Address_____ Apt #_____

City_____ State_____ Zip_____

INSURANCE INFORMATION

Primary Insurance _____ Telephone # _____

Address _____ City _____ State _____ Zip _____

Name of Insured _____ Insured's Social Security # _____

Insured's Date of Birth _____ Policy # _____ Group # _____

Secondary Insurance _____ Telephone # _____

Address _____ City _____ State _____ Zip _____

Name of Insured _____ Insured's Social Security _____

Insured's Date of Birth _____ Policy # _____ Group # _____

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ADDITIONAL INFORMATION

Nearest relative or friend not living with you _____ Telephone# _____
Address _____ City _____ State _____ Zip _____

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INSURANCE ASSIGNMENT AND MEDICAL RECORDS RELEASE:

I, The Undersigned, do hereby authorize my insurance carrier(s) to pay directly to Sundance Medical Center, the insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for any charges not covered by said insurance carrier(s), including co-payments and /or deductible amounts. I, the undersigned, also do hereby give my permission to Sundance Medical Center, to furnish my insurance carrier(s), any and all information pertaining to my medical records.

_____ _____

Patient's Signature or Authorized Person Date

Consent to Receive Information.

I, _____, allow the understated to discuss or receive my medical information.

_____

Name

_____

Name

_____

Name

_____

Patient's Signature

_____

Date

PLEASE READ AND SIGN THIS FORM

FINANCIAL RESPONSIBILITY:

Our billing department will file insurance claims for you as a courtesy. You are responsible to provide us with the correct information regarding your insurance and inform us of any changes immediately. You are also responsible for know your insurance's rules regarding co-pays, deductibles, and when prior authorization is needed for tests. Every policy is different and we CAN NOT be responsible for knowing what every carrier covers or disallows.

We do accept assignment from Medicare, which means we collect a portion of our set fee as set by Medicare. You are still responsible for the annual deductible and for 20% of what Medicare allows.

*** There will be a $5 fee charged for forms completed by our staff and /or physicians.

*** Please give our office a courtesy call 24 hours I advance for any appointment you can not keep. There will be a $25 charge for any missed appointment and a $45 charge for any missed ultrasound appointments.

PLEASE BE ADVISED OF THE FOLLOWING INFORMATION:

DISABILITY: THE PHYSICIANS IN THIS CLINIC WILL NOT COMPLETE DISABILITY FORMS FOR A DISABILITY INCURRED PRIOR TO BEING SEEN AT THIS CLINIC. THE PHYSICIAN ORIGINALLY DECLARING THE DISABILITY MUST FILL OUT THESE FORMS.

CONTROLLED SUBSTANCE: PRESCRIPTIONS FOR THOSE POTENTIALLY ADDICTIVE SUBSTANCES (NARCOTICS, SEDATIVES, SLEEPING AIDES, AND DIET PILLS) ARE HIGHLY REGULATED BY OUR DOCTORS AND ARE ONLY GIVEN FOR A SHORT TERM VERY LIMITED BASIS FOR VERY SPECIFIC CONDITIONS. IF THERE ARE ALTERNATIVE DRUGS OR TREATMENT WE USE THEM FIRST.

COLLECTION POLICY:

Patient Name: _____

I, _____ hereby, agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a Collection service due to lack of payment on my part, I agree to pay all collection/legal fees that may be added to my account.
Return Checks: a $25 NSF fee will be charged for check initially returned unpaid by your bank. If the same check is returned unpaid a second time, it may be referred to a collection service for recovery.

_____ _____
Signature Patient or Responsible Party Date

_____ _____
Signature Witness Date

IF THE PATIENT IS A MINOR (UNDER AGE 18) THE PARENT/LEGAL GUARDIAN NEEDS TO SIGN HERE TO AUTHORIZE THE ABOVE INFORMATIONAND GIVE PERMISSION TO TREAT.

_____ _____
Signature Date

*** CHARGE AUTHORIZATION: By signing the bottom of the page you authorize payments by phone to your account.

I HAVE READ AND UNDERSTOOD ALL OF THE ABOVE *

_____
Signature