

SOUTHSIDE MEDICAL CLINIC

◆ Michael J. Smith, M.D., F.A.A.P. ◆ Thomas P. Peller, M.D., F.A.C.P.
◆ Jenifer I. Bassett, M.D., F.A.A.P. ◆ Patricia T. Sontag, F.N.P.

714 West Hamilton Avenue • Eau Claire, WI 54701 • Telephone: 715-830-9990 • FAX: 715-830-9995

PATIENT INFORMATION

THANK YOU FOR CHOOSING OUR OFFICE! In order to serve you properly, we need the following information. Please Print. All information will be confidential.

Patient's Legal Name (Last) _____ (First) _____ (MI) _____ Patient # _____
SSN _____ Birthdate _____ Male Female
Address _____ City _____ State _____ Zip _____
Home Phone# _____ Cell Phone# _____
Check appropriate box: Minor Single Married Divorced Widowed Separated
Patient's Employer _____ Work Phone _____
Spouse/Parent's name _____ Employer _____ Work Phone _____
If patient is a student, name of school/college _____
Whom may we thank for referring you? Dr. _____, Phonebook, or Other _____
Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship to Patient _____
Address _____ Home Phone _____
Birthdate _____ Employer _____ Work Phone _____
Is this patient currently a patient at our office? Yes No

INSURANCE INFORMATION

Primary Insurance _____ ID # _____ Group # _____
Policy holder _____ Employer _____ Work Phone _____
Relationship to patient _____ Birthdate _____ SSN _____
Secondary Insurance _____ ID # _____ Group # _____
Policy holder _____ Employer _____ Work Phone _____
Relationship to patient _____ Birthdate _____ SSN _____

Amounts are due in full upon receipt of our statement. Although some payment arrangements may be available, you are urged to use your own bank or credit union to finance extended payments.

Please turn page over and sign and date form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to understand your benefits and coverage and to obtain proper certification when needed. It is also your responsibility to pay any deductible, co-insurance, or any other balance not paid by insurance.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize the disclosure of portions of my medical record.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to Dr. Michael J. Smith/Dr. Jenifer I. Bassett/ Dr. Thomas Peller/Patricia Sontag, FNP.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

*Signed: _____ Date: _____
Spouse/Parent/Guardian _____ Date: _____*

Patient Signature on File for Medicare Claims and any other insurance, including Medigap Insurance.

I request that payment of authorized Medicare benefits and/or Insurance benefits be made either to me or on my behalf to: Michael J. Smith, M.D.,F.A.A.P./Jenifer I. Bassett, M.D.,F.A.A.P/ Thomas P. Peller, MD., F.A.C.P/ Patricia Sontag, F.N.P. For any services furnished to me by that provider. I authorize any hold of medical information about me to release to the Health Care Financing Administration to determine these benefits or the benefits payable for related services.

Signed: _____ Date: _____

This authorization is in effect until I choose to revoke it.