



Gary P. Jones, MD, FACS

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Tax ID # 61-1436519

Today's Date Doctor you are seeing today

Name: Sex: Date of Birth: Race:
Address: City: ST: Zip:
Home Phone: Wk Phone: Cell Phone
E-mail: Patient's SSN: Marital Status:
Employer: Referred by:
Name of Spouse/Guardian: Date of Birth: SSN:
Name of relative/friend not residing with you:
Relationship: Phone:
Additional contact name: Relationship: Phone:

PRIMARY INSURANCE INFORMATION - Please present your insurance card(s) to the receptionist.

Insurance Name:
Policyholder's Place of Employment: Address & Phone:

SECONDARY INSURANCE INFORMATION - Please present your insurance card(s) to the receptionist.

Insurance Name:
Policyholder's Place of Employment: Address & Phone:

OTHER INFORMATION

Is your visit related to an on-the-job injury? Is your visit related to an auto accident? If yes, date of injury
Claim # Adjuster Name: Phone:
Attorney Name: Phone:
Address: City: ST: Zip:

FINANCIAL POLICY, RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

Payment for service is due at the time services are rendered unless payment arrangements have been approved, or if you belong to an HMO. Any and all copayments due are to be paid prior to seeing the provider. We accept cash, checks, and credit cards.

We will be happy to assist you in processing your Insurance claim. Insurance coverage is a contract between you and your insurance company, and you are ultimately responsible for the payment of this bill, except if you belong to an HMO, in which case you may be responsible only if you failed to secure prior authorization for services. Balances older than 90 days will be subject to interest charges at the rate of up to 1.5% per month.

I hereby authorize and direct my insurance company to make payments to my physicians, providers, and/or associates for services rendered, and I am financially responsible for non-covered services.

I also authorize the provider to release any information including but not limited to medical records required to process this claim. A photocopy of this assignment shall be considered as effective and valid as the original copy.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

PATIENT SIGNATURE DATE:
PARENT/GUARDIAN (if patient is a minor)