



### New Patient Information

Patient's Name (Please Print)			S.S. #	Marital Status					Sex		Birth Date	Age	Religion (Option)
Street Address			Permanent	Temporary	City and State			Zip Code		Home Phone #			
Patient's or Parent's Employer			Occupation (Indicate if student)					How long employed		Bus. Phone #			
Employer Street Address			City and State					Zip Code					
Drug Allergies, If Any													
Spouse or Parent's Name			S.S. #	Birth Date									
Spouse or Parent's Employer			Occupation (Indicate if student)					How long employed		Bus. Phone #			
Employer's Street Address			City and State					Zip Code					
* Spouse's street address, if divorced or separated			City and State					Zip Code		Home Phone #			

**Please read: All charges are due at the time of services.**

**Practice Disclaimer**

Atlanta I.D. Group, P.C. will file your insurance and accept contract terms as applicable on all participating plans. However, **any** charges denied for any reason including lack of referral, participation status (out of network), valid card presented at time of visit, coverage terminated after service dates etc., **will become the responsibility of the patient.** This policy will be inclusive to hospital patients visiting our practice for their follow-up visits.

**Patient Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office bookkeeper.

I request that payment of authorized Medicare/Other Insurance company benefits be made either to me or on my behalf to \_\_\_\_\_ for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 11285 of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding this information, including all information on HIV / AIDS).

Signature \_\_\_\_\_

Date \_\_\_\_\_