

Performance Therapeutics

Patient Information Form

Name:		Date:	
Address		Apt.#	
City:		Home Phone #:	
State:	Zip:	Wrk / Cell Phone #:	
SS#:	Birth Date:		Age:
Driver's License #:	State:	Marital Status: S M D W	
Sex: M F	Retired: Y N	Disabled: Y N	Race:
Employer:			
Employer's Address		City:	State: Zip:
Spouse's Name			
Spouse's SSN		Birthdate:	
Spouse's Employer		Phone:	
Emergency Contact:		Phone:	
I was referred to Performance Therapeutics by:			
Insurance Holder / Financially Responsible Party		Please present Ins. Card to Receptionist	
Name		Driver License#:	
Address		Apt.#	
City:		Home Phone #	
State:	Zip:	Wrk / Cell Phone #:	
SS#:	Birth Date:		Age:
Employer:			
Employer's Address		City:	State: Zip:

FamilyCare Billing Policy

FamilyCare Specialists files insurance only for selective HMOS and PPOs (see Receptionist for specific companies). We also file and accept assignments for Medicare. Any co-payments, deductibles and/or coinsurance will be the patient's responsibility. If you are not covered by one of these companies, payment in full will be expected at the time of service unless prior arrangements have been made. Any necessary information you may need to file for reimbursement will be provided.

I hereby agree to the policy above and authorize FamilyCare Specialists to provide me (or my child) with medical care. I authorize FamilyCare Specialists to release medical information to my Insurance Company, if necessary, to process a claim. This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for other services rendered, including reasonable attorney's fees and costs of collection in the event of a default.

Patient Signature / Child's Name (Minor)

Date

Signature of Parent or Guardian

Date

MEDICARE ONE-TIME AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Familycare Specialists for any services furnished rendered me by that provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature / Child's Name (Minor)

Date

Witness

Date