



## Convenient Care Family Medicine Patient Billing & Insurance Information

Due to the exceeding amount of information required for our office to process/submit a claim, please complete **ALL PORTIONS** of this form. It is also crucial that you supply the physician and staff with your most current and up-to-date insurance information. You will be asked to update this information a minimum of annually. Your patience and diligence is much appreciated.

Name Mr/Mrs Miss/Ms. Dr.		Last		First		MI	
Address		Apt#	City	State	Zip code	Phone #	Cell # (If you want to use as secondary contact)
SSN #		Date of birth		Age	Sex	E-mail address	
Employer:		Employer Address		City	State	Work/ Bus Phone	
Spouse/or Guardian/ Parent's Name						Work Phone	
Emergency Contact Name		Address			Phone		
Referred to this office by:							
Last Physician seen:							

**Primary Insured Card Holder or Responsible party** – If other than above

**\*Must have name, date of birth and SS# to file insurance**

*Name		*Date of birth		*Social Security #	
Address		Phone #		Relationship to patient (Parent, Guardian, Spouse)	
Employer		Company Address	City	State	Bus phone #

Method of payment:  Cash  Check  Credit card  Insurance

**NOTICE:** This clinic does not accept or file **Medicare** or **Medicaid**. If you would like to be seen by a health care professional that accepts Medicare or Medicaid please tell the receptionist and we will provide you with the names of area clinics that participate in these programs.

**Name of Insurance Company** \_\_\_\_\_

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 pay any deductible amount, co-insurance, or any other balance not paid by your insurance.**

**Please read & sign the following:**

I directly assign all medical / surgical benefits to: Kelly S. Doggett D.B.A. *Convenient Care Clinic*. **I understand that I am financially responsible for all charges** whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

**SIGN HERE** \_\_\_\_\_ **DATE** \_\_\_\_\_