STEPHEN E. FRY M.D., P.C.
CONFIDENTIAL PATIENT INFORMATION

Today's Date:_____

How did you hear about us? _____

PATIENT INFORMATION: Please fill in ALL portions of this form, unless otherwise instructed.

Last Name:_____ **First:**_____ **Middle:**_____

Permanent Address:_____ **City:**_____ **State:**_____ **Zip Code:**_____

Temporary Address:_____ **City:**_____ **State:**_____ **Zip Code:**_____

Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____

Date of Birth:_____ **Age:**_____ **Sex: M / F** **E-Mail:**_____

Social Security Number:_____ **Marital Status:**_____

Occupation:_____ **Employed By:**_____

Work Address:_____ **City:**_____ **State:**_____ **Zip Code:**_____

In Case of Emergency, Contact:_____**Phone:**_____**Relationship:**_____

RESPONSIBLE PARTY INFORMATION:

Last Name:_____ **First:**_____ **Middle:**_____

Address:_____**City:**_____**State:**_____**Zip Code:**_____

Home Phone:_____ **Work Phone:**_____

Date of Birth:_____ **Social Security Number:**_____

Relationship to Patient:_____ **Employed By:**_____

Work Address:_____**City:**_____**State:**_____**Zip Code:**_____

INSURANCE INFORMATION: (A *current* insurance card is required for today's visit)

Primary Insurance:_____ **Phone:**_____

Address:_____**City:**_____**State:**_____**Zip Code:**_____

Name of Insured:_____ **Policy Number:**_____ **Group Number:**_____

Relationship to Patient:_____ **Co-pay Amount:**_____ **Effective Date:**_____

Secondary Insurance:_____ **Phone:**_____

Name of Insured:_____ **Policy Number:**_____ **Group Number:**_____

Address:_____ **City:**_____ **State:**_____ **Zip Code:**_____

Turn Over: Additional information on the other side of this form.

Stephen E. Fry M.D., P.C.

CONSENT FOR TREATMENT AND INSURANCE AUTHORIZATION

I, or my representative, recognizing the need for medical care, consent to treatment, and any diagnostic procedures by my physician or therapist. I agree that this office may release records regarding my treatment to my insurance company or other third party responsible for payment of my medical expenses, including review activities related to my physician's with my health plan.

I understand and agree to be responsible for payment of any expenses, or services that are not covered by my insurance.

I also understand that if I suspend or terminate my care and treatment, any fees from professional services rendered me will be immediately due and payable. Furthermore, any charges, fees, court costs, and reasonable attorney's fees incurred as a result of collection efforts will be added to my account balance in the amount equal to 20% or no less than $20.00

In the event my physician agrees to accept assignment of my insurance, I will provide all insurance information before my consultation. If my insurance company has not satisfied my account in full within 45 days, I agree to pay in full with in ten(10) days of notification of non-covered services.

Regarding insurance plans where my physician is a participating provider, I shall pay all co-pays and deductible prior to treatment.

<u>MISSED APPOINTMENT POLICY:</u> If you are unable to keep your scheduled appointment, please notify our office at least 24 hours in advance. Failure to do so will result in a $25.00 charge to the patient for the missed appointment.

I certify that I have read and understand the above policy. I guarantee payment of all charges incurred as a patient here of Dr. Stephen E. Fry M.D., P.C.

Signed:_____ Date:_____

Parent/Guardian (if patient is a minor):_____ Date:_____