SELF-PAY OR INSURANCE INFORMATION

Are you a self-pay patient not using insurance? YES _____ or NO _____

(Please complete this section if you are using insurance)

PRIMARY INSURANCE:

_____

Insurance Carrier Name

_____ _____

Member ID Number Group Number

_____

Claims Mailing Address City State Zip Code

_____ _____ _____

Policy Holder's Name Date of Birth Social Security #

_____

Relationship to Patient

SECONDARY INSURANCE:

_____

Insurance Carrier Name

_____ _____

Member ID Number Group Number

_____

Claims Mailing Address City State Zip Code

_____ _____ _____

Policy Holder's Name Date of Birth Social Security #

_____

Relationship to Patient

HIPAA PHI COMMUNICATION

Please provide your consent below to use your PHI for the following. If left blank, we are unable to communicate with anyone regarding your personal health information. **No Exceptions.**

You may contact me at the phone number(s) provided in my patient information with test results and other medical information. I have verified and listed the numbers that I prefer you to call. **(INITIAL HERE):** _____

You may leave a detailed message on my answering machine or voicemail regarding my test results and other medical information. **Yes** ____ **No**_____

Please list any persons to whom our staff may discuss and/or disclose your health or financial information below**. (PLEASE PRINT LEGIBLY. If left blank, we are unable to communicate with anyone but you, our patient. No Exceptions!)**

(PLEASE CIRCLE)

NAME	**RELATIONSHIP**	**PHONE NUMBER**	**MEDICAL**	**FINANCIAL**
			YES/NO	YES/NO
			YES/NO	YES/NO
			YES/NO	YES/NO