Judith A. Ingalls, MD

PATIENT INFORMATION

PATIENT NAME: _____

LAST FIRST MIDDLE

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME #: (_____) _____-_____ CELL #: (_____) _____-_____ WORK #: (_____) _____-_____

EMAIL ADDRESS: _____

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY NUMBER: _____-_____-_____

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: (circle one) SEX: (circle one) FEMALE MALE

SELF SPOUSE CHILD OTHER

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

PATIENT'S EMPLOYER INFORMATION:

COMPANY: _____ CITY: _____ PHONE #: (_____) _____-_____

ALLERGIES TO MEDICATION: _____

SECOND HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SECOND HOME PHONE #: (_____) _____-_____

RESPONSIBLE (OR INSURED) PARTY INFORMATION

RESP. PARTY NAME: _____

LAST FIRST MIDDLE

ADDRESS: _____

DATE OF BIRTH: _____/_____/_____ SEX: (circle one) FEMALE MALE

HOME PHONE #: (_____) _____-_____ WORK PHONE #: (_____) _____-_____

SOCIAL SECURITY NUMBER: _____-_____-_____

RESPONSIBLE PARTY'S EMPLOYER INFORMATION:

COMPANY: _____ CITY: _____ PHONE #: (_____) _____-_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

ADDRESS: _____ PHONE: _____

CONTRACT (ID#) NUMBER: _____ SUBSCRIBER'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP NUMBER: _____

COPAYMENT AMOUNT: $ _____ INSURED'S DATE OF BIRTH: _____/_____/_____

SECONDARY INSURANCE COMPANY: (Medicare pts Only) _____

ADDRESS: _____ PHONE: _____

CONTRACT (ID#) NUMBER: _____ SUBSCRIBER'S NAME: _____

COPAYMENT AMOUNT: $ _____ INSURED'S DATE OF BIRTH: _____/_____/_____

WE APPRECIATE THE OPPORTUNITY OF SERVING YOU.

WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE.

OFFICE POLICY ON PAYMENT:

All accounts over 60 days will be charged an interest rate of 1 1/2 percent per month (18% per annum) or a $2.00 minimum. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, including a reasonable attorneys fee.

OFFICE POLICY ON FAILED APPOINTMENTS:

Failed appointments are a significant contributor to rising health costs. Cancellation of appointments must be received 24 hours prior or a fee will be charged based on the length of the missed appointment.

INSURANCE POLICY:

Insurance provides for your reimbursement on allowed medical charges. We will be happy to submit to insurance carriers we are contracted with . You are responsible for all copays, deductibles and charges not covered by insurance. All other carriers are subject to payment at time of service. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

I hereby authorize payment directly to the business office of the physician for the medical and or surgical benefits, if any, otherwise payable by me for services.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me as my HIPAA form states. I understand that this medical information may be used for purpose when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

I have read the above and accept financial responsibility in full for this account.

SIGNED: _____ DATE: _____

Patient, Parent, or Guardian

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME: _____

PHONE NUMBER: _____ RELATIONSHIP: _____