MARK R. KAISER, M.D., P.A.

Please provide your insurance card(s) and photo id to receptionist along with this form.

PATIENT INFORMATION *(Please Print)*

Name _____
Last *First* *Middle*

Mailing Address _____
City *State* *Zip*

Home Phone _____ Work Phone _____ Cell _____
Area Code *Area Code* *Area Code*

What is the best number to contact you during the hours from 8AM to 5PM? ❑ Home ❑ Work ❑ Cell

Date of Birth _____ Age _____ Sex _____ Marital Status _____ SS# _____

PARENT OR RESPONSIBLE PARTY *(if different from patient)*

Name _____
Last *First* *Middle*

Mailing Address _____
City *State* *Zip*

Home Phone _____ Work Phone _____ Cell _____
Area Code *Area Code* *Area Code*

Date of Birth _____ Sex _____ SS# _____

INSURANCE INFORMATION

Primary Insurance _____

Name of Insured _____

Insured's Birthdate _____

Patient Relationship to Insured _____

Secondary Insurance _____

Name of Insured _____

Insured's Birthdate _____

Patient Relationship to Insured _____

Other family members that are patients _____

Pharmacy of choice _____ Phone _____

In case of Emergency, who should be notified? _____ Phone _____

Referred by: _____ Primary Care Physician _____

Payment Policy: Payment is required for all services at the time they are rendered. We accept payment in cash, check or credit card. You will be asked to pay any unmet deductible, co-payments and non-covered services. Your signature below signifies your understanding and willingness to comply with this policy.

Assignment of Medical Benefits: I request that payment of authorized Medicare or Insurance company benefits be made on my behalf to Mark R. Kaiser, M.D., P.A. for any services furnished me by that party who accepts assignment. Regulations pertaining to Medicare assignment apply. I understand that my contract is between my insurance company and myself and that I am financially responsible for all charges until the bill is paid in full.

Medicare Part A and Part B: I certify that the information given by me in applying for payment under Title XVIII of Social Security act is correct. I request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. Regulations pertaining to Medicare assignment of benefits also apply.

Authorization to Release Information: I authorize any holder of medical or other information about me to release to Social Security Administration, its intermediaries or carriers, any other insurance company or to my physician, any information needed for this or a related Medicare or other insurance company claim. I authorize any holder of medical or other information about me to release to my physician any of my medical records necessary to provide a continuity of care relating to my present condition or to facilitate payment of this service. I also acknowledge and authorize my physician to release my medical records relating to this specific service to my treating physicians.

Patient or Responsible Party Signature _____ **Date** _____

OFFICE USE ONLY: ❑ **Copy of insurance card (both sides) attached** **Acct #:** _____

Verified: _____ _____ _____ _____ _____ _____ _____

MARK R. KAISER, M.D., P.A.

Please provide your insurance card(s) and photo id to receptionist along with this form.