



# Family Physicians, LLC

14 Medical Park • Valley, AL 36854 • Phone: 334-756-4136

## PATIENT INFORMATION FORM (Please Print Clearly)

Date: \_\_\_\_\_

PATIENT'S NAME		SOCIAL SECURITY #		BIRTHDATE		AGE			
STREET ADDRESS				CITY AND STATE		ZIP CODE		HOME PHONE #	
REFERRED BY:				MARITAL STATUS		DRIVER'S LICENSE #		WORK PHONE #	
PATIENT'S EMPLOYER				OCCUPATION (INDICATE IF STUDENT)				CELL PHONE #	
EMPLOYER'S ADDRESS				CITY AND STATE				ZIP CODE	
HERE TO SEE WHICH PROVIDER:									
SPOUSE (OR GUARDIAN'S) NAME: OTHER THAN SPOUSE									
1. EMERGENCY CONTACT: (OTHER THAN SPOUSE)						RELATIONSHIP		PHONE #	
2. EMERGENCY CONTACT: (OTHER THAN SPOUSE)						RELATIONSHIP		PHONE #	

WE REQUIRE ALL PATIENTS TO SHOW THEIR INSURANCE OR MANAGED CARE MEMBERSHIP CARD, AND THEIR DRIVER'S LICENSE, SO THAT WE MAY MAKE COPIES FOR OUR PERMANENT RECORD.

WE CANNOT RENDER SERVICES ON THE ASSUMPTION THAT OUR CHARGES WILL BE PAID BY AN INSURANCE COMPANY. ALL SERVICES ARE CHARGED DIRECTLY TO THE PATIENT, AND HE OR SHE REMAINS PERSONALLY RESPONSIBLE FOR PAYMENT. AS A COURTESY, HOWEVER, WE WILL PREPARE ANY NECESSARY REPORTS AND ITEMIZATION TO ASSIST IN MAKING COLLECTIONS FROM INSURANCE COMPANIES AND WILL CREDIT ANY SUCH COLLECTIONS TO THE PATIENT'S ACCOUNT.

\*\*\*\*\*PAYMENT AND RELEASE OF INFORMATION AUTHORIZATION\*\*\*\*\*

I, \_\_\_\_\_ HEREBY AUTHORIZE THE DOCTOR'S OFFICE, LLC TO FURNISH INFORMATION CONCERNING MY PRESENT ILLNESS. I DIRECT THE INSURER TO PAY WITHOUT EQUIVOCATION, DIRECTLY TO THE PHYSICIAN, ALL BENEFITS DUE HIM AS A RESULT OF THIS CLAIM. ALTHOUGH COVERED BY INSURANCE, I AM AWARE THAT I AM PERSONALLY RESPONSIBLE FOR ALL CHARGES. I AGREE TO PAY ANY COLLECTION AND/OR ATTORNEY FEES ASSOCIATED WITH MY FAILURE TO PAY MY DEBT. A PHOTOSTATIC COPY OF THIS AUTHORIZATION WILL BE AS VALID AS THE ORIGINAL.

I HEREBY AUTHORIZE THE DOCTORS OFFICE LLC TO RELEASE THE MEDICAL INFORMATION CONTAINED IN MY CHART TO MY INSURANCE CARRIER FOR THE PURPOSE OF CONDUCTING CHART REVIEWS, AS NECESSARY.

*A 5% LATE FEE IS DUE & PAYABLE ON ALL PATIENT DUE BALANCES GREATER THAN 30 DAYS PAST DUE.*

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date