

**PATIENT INFORMATION**

Reason for appt: \_\_\_\_\_ Referred by: \_\_\_\_\_

Date of Injury? \_\_\_\_\_ Work Related? \_\_\_\_\_ Today's Date: \_\_\_\_\_

Primary care Physician (Family Doctor) \_\_\_\_\_

Patient's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Social Security # \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Marital Status S M D W

Patient's Employer: \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Employer Contact \_\_\_\_\_

If Minor: Parent's Names \_\_\_\_\_

**IF THE PATIENT IS A MINOR WHO WILL BE RESPONSIBLE FOR THIS ACCOUNT?**

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Responsible Party Employer \_\_\_\_\_

**SPOUSE INFORMATION**

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Phone \_\_\_\_\_

Employer Address \_\_\_\_\_

**EMERGENCY CONTACT NAME** \_\_\_\_\_

**RELATIONSHIP TO PATIENT:** \_\_\_\_\_ **Phone** \_\_\_\_\_

**INSURANCE INFORMATION** (we will copy all insurance cards and your driver's license)

**PRIMARY INSURANCE** \_\_\_\_\_ **Policy Holder** \_\_\_\_\_

Certificate ID# \_\_\_\_\_ Group Number# \_\_\_\_\_

2nd Insurance \_\_\_\_\_ **Policy Holder** \_\_\_\_\_

Certificate ID# \_\_\_\_\_ Group Number# \_\_\_\_\_

Medicare Supplement? \_\_\_\_\_ Employee Retirement Policy? \_\_\_\_\_

**AUTHORIZATION FOR TREATMENT:**

I hereby give permission for treatment (Medical/Surgical) by Jerome Lamb, M.D.

**AUTHORIZATION TO RELEASE INFORMATION:**

I hereby authorize Jerome Lamb, M.D. to release any/all information necessary: to process claims for payment of services rendered, to comply with completion of forms for Missouri Division of Worker's Compensation, to the referring party (physician/employer/attorney, as specified at referral), and it must be understood that the right of such information to be privileged is hereby waived.

**CONSENT TO USE NAME OR PHOTOGRAPH:**

I hereby consent that my name or child's name and/or photograph of any part of me or my child, may be used by Jerome Lamb, M.D. for such purpose as he may desire in connection with his research, writing and professional activities, even though such use may be for advertising purposes or purposes of trade with the exception of; \_\_\_\_\_.

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN/PROVIDER:**

I hereby authorize payment of benefits to Jerome Lamb, M.D. for Medical/Surgical services rendered, including those involving Medicare and Champus. I accept responsibility for the deductible, co-payment and non-covered services and will make such payments as determined for the time of service, or with prior arrangements, payment will be rendered within a period of not to exceed 60 days from the time of service. There will be a re-billing charge of 1 ½% or \$10.00, whichever is greater for patient account balances that exceed 31 days.

**FINANCIAL POLICY:**

**If you have no insurance,** payment for services is due at the time services are rendered unless prior payment arrangements have been approved. To assist you, we accept cash, check, Mastercard or Visa.

**If you have insurance,** we will file it for you provided we have your assignment of benefits. However, your insurance company thus making payment to us for our services, your responsibility. If, at the end of thirty working days your insurance has not made payment to us, payment is due in full from you. Please keep in mind that as we are very diligent to pre-authorize and certify the procedures we schedule, benefits vary from policy to policy and knowledge of co-pays, deductibles, etc., is your responsibility.

**If you belong to an RHO or PPO in which we participate,** we follow the guidelines set forth in that plan. Please be sure to bring a referral form with you to your appointment, if required. Services will be rendered without a referral from if the required financial responsibility form is completed and signed by you. Please check with the receptionist at this time to confirm that we are a participating provider with your plan.

**PRESENTATION OF THE REFERRAL FORM IS THE PATIENT'S RESPONSIBILITY AT TIME OF THE APPOINTMENT.**

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in management of your account. Re-billing charge as stated above will still apply. Should the account be referred for collection, the undersigned shall pay reasonable attorney fees, court costs and collection expenses. These additional costs will be added to the account balance.

If you have any questions about the above information or uncertainty regarding insurance coverage, please do not hesitate to ask NOW. We are here to assist you.

**INSURANCE WAIVER FOR COSMETIC/SELF-PAY PATIENTS:**

I understand procedures of a cosmetic nature are not insurance reimbursable. Despite this, if I choose to have my charges submitted to insurance for possible payment of any components deemed "medically necessary," I understand this is non-customary and will incur work on the part of my surgeon &/or his staff. I understand the fees quoted for my cosmetic surgery discount expenses related to billing, collection & pre-authorization. If I request pursuit of insurance payment, I waive any managed care contractual obligation for discount and agree to pay according to the physician's customary fee schedule. I agree to not profit by having this surgery billed to my carrier, i.e., I will not receive any refunds in excess of my pre-payment.

**"I HAVE READ THE ABOVE AND CONSENT AND AGREE TO ABIDE BY THE TERMS AS STATED."**

\_\_\_\_\_  
Patient/Responsible Party  
Date