New Patient

(Please provide your photo ID and Insurance Cards)

Patient Information:

Last Name: _____ First Name: _____ Middle Name: _____

D.O.B: _____ /_____ /_____ Gender: __Male __ Female Social Security #: _____-_____-_____ Language: _____

Cell Phone: (_____) _____-_____ Home Phone: (_____) _____-_____ Email address: _____

Emergency Contact Name: _____ Relationship:_____ Phone #:(_____) _____-_____

Address: _____ City: _____ State: _____Zip: _____

Employment Status: ____Currently Working ___Unemployed ____Retired ____Temporarily Disabled ___ Legally Disabled

Primary Care Physician: _____ Phone #: (_____) _____-_____ Referred By:_____

Description of the accident/Injury: _____

_____

_____

Body Part(s) Injured: _____

Primary Insurance Information:

Ins. Company Name: _____ Insurance Company Phone #:(_____) _____-_____

Policy Holder Name: _____ Insurance ID #: _____Group #: _____

Address: _____ City: _____ State: _____Zip: _____

Secondary Insurance Information:

Ins. Company Name: _____ Insurance Company Phone #:(_____) _____-_____

Policy Holder Name: _____ Insurance ID #: _____Group #: _____

Address: _____ City: _____ State: _____Zip: _____

Information Disclosure Authorization

I authorize Community Medical Wellness P.C. to obtain / release all medical records for treatment rendered pertaining to my car accident-related injury. I authorize payment of medical benefits to Community Medical Wellness P.C.

_____ _____ _____

Print Name Signature Date

OUT OF NETWORK DISCLOSURE FORM AND FINANCIAL AGREEMENT

We understand that healthcare costs can be worrisome. We are an out of network health care provider with most health plans. In many instances, your health plan may not fully pay our charges for medical services. As a result, we have the obligation to bill you for coinsurances, deductible and cost share amounts for non-covered services. You, the patient (or patient's guardian if a minor) agree that you will be responsible for these potential fees. Should your insurer remit reimbursement to you directly, you agree to forward these reimbursements to the PRACTICE in a timely manner. Insurance checks must be endorsed to the PRACTICE. (Signed on the back) We recognize that not all patients will be able to afford their patient costs share amount. We have therefore created a Financial Hardship Policy. This policy legally permits us to reduce and, in some cases, waive the patient cost share amount. If you believe you might qualify for financial assistance, please ask our staff for a copy of the Financial Hardship Policy. Should payment for said services not be forthcoming, the matter may be referred to an attorney for collection. If the matter is sent to an attorney, in addition to the full balance due, the patient will also be responsible for legal fees and court costs in connection with the collection of the said amount.

AGREED TO BY: _____(Print Name)

AGREED TO BY:_____(Sign Name)

AGREED TO BY:_____(Minor Legal Guardian Signature)

DATE: _____