

### NEW PATIENT INFORMATION

Patient Name:	Date of Birth:	
Mailing Address:	Cell Phone:	
City/State	Zip:	Home Phone:
Marital Status: S M W SEP D	Email:	

### PATIENT/EMPLOYER INFORMATION

Patient's Occupation:	Work Phone No:
Patient's Employer:	
Emp. Address:	
City/State	Zip:

### INSURED PERSON (If Not Patient)

Name:	Phone No:
Mailing Address:	
City/State	Zip:

### INSURANCE

<input type="checkbox"/> None		
<input type="checkbox"/> PPO or <input type="checkbox"/> HMO (name):	Medicare ID#:	
Primary Insurance:	Policy/ID#:	Group:
Subscriber's Name:	Relationship:	
Secondary Insurance:	Policy/ID#:	Group:
Subscriber's Name:	Relationship:	

### REFERRED BY

<input type="checkbox"/> Patient (name)	<input type="checkbox"/> Friend/Relative
<input type="checkbox"/> Doctor (name)	<input type="checkbox"/> Internet/Website

I understand and agree to the following: Health Associates Medical Group is a fee for service clinic and all services are to be paid for AT THE TIME OF SERVICE PROVIDED; Health Associates does not bill insurance companies, however, a superbill will be provided when appropriate to bill my insurance company. I authorize release of information relating to any claims submitted to insurance companies by Health Associates. HMO insurances will not cover any services at Health Associates. We are not Medicare providers, therefore, services cannot be billed by our office or by the patient. I also understand that some of my testing is considered "not usual and customary" and may not be covered by my insurance company. I understand that I will be expected to pay this amount at the time of service. I can pay by Visa, MasterCard, Discover Card, American Express, personal check or cash.

Health Associates Medical Group is not a 24-hour acute care facility, although we do have an answering service. We do not have physicians on call in the evenings or on weekends. If you cannot get through to us and you have an emergency or urgent problem, we recommend you go immediately to your nearest walk-in clinic or Emergency Room. Please contact us as soon as possible during our normal office hours regarding your problem if you are seen at another facility.

**Health Associates Medical Group charges \$100 for missed appointments without 24 hours notice.**

X \_\_\_\_\_  
Signature

\_\_\_\_\_  
Date