Machen FamilyMedicine

Shane G. Machen, DO

Today's date:	

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ AD	❑ Insurance Plan	❑ Internet

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Email address:	Cellular phone no:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Blue Cross of ID	❑ Regence	❑ Medicare	❑ Pacific Source	❑ IPN

❑ DMBA	❑ Aetna	❑ Cigna	❑ Idaho Medicaid	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Effective Date:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

HIPAA NOTICE OF PRIVACY PRACTICE

I have been given a copy of the HIPAA NOTICE OF PRIVACY PRACTICE.

Patient/Guardian signature

Date

ADDITIONAL FAMILY MEMBERS SEEN HERE:

Name:	Date of Birth:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FINANCIAL INFORMATION

We are happy to file the claim with your insurance carrier, however all charges are your responsibility. Any estimate by this office regarding insurance benefits is only a guideline. This office makes no guarantee of the insurance payment as estimated.

Deductible, estimated co-payments, and any portion not covered by your insurance is due at the time of your visit.

We accept cash, personal checks, Visa, Mastercard, Discover and American Express.

There will be an additional fee of $25.00 for returned checks. Delinquent accounts will be promptly referred to a collection agency.

I have read and understand the above stated financial policies of this office.

Patient/Guardian signature *Date*

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the doctor. I understand that I am financially responsible for any balance. I also authorize Machen Family Medicine or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*