



**ADDITIONAL FAMILY MEMBERS SEEN HERE:**

Name:

Date of Birth:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
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**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*