TRANSCEND MEDICAL GROUP

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NEW PATIENT FORM

PATIENT NAME: _____ (last) _____ (first) _____ (middle)

ADDRESS: _____

_____ (city) _____ (state) _____ (zip)

SOCIAL SECURITY # _____ **SEX: M F** **DATE OF BIRTH:** _____

HOME # _____ **CELL #** _____ **WORK #** _____

MARITAL STATUS: S M D W **EMERGENCY CONTACT NAME & NUMBER** _____ (name) _____ (phone #)

PRIMARY INSURANCE:

CLAIM MAILING ADDRESS: _____

SUBSCRIBER NAME: _____ **PATIENT RELATIONSHIP TO SUBSCRIBER:** _____

EMPLOYER: _____ **PHONE #** _____

EMPLOYER ADDRESS: _____

SUBSCRIBER SOCIAL SECURITY # _____ **DATE OF BIRTH:** _____

INSURANCE ID # _____ **PLAN / GROUP #** _____

SECONDARY INSURANCE:

CLAIM MAILING ADDRESS: _____

SUBSCRIBER NAME: _____ **PATIENT RELATIONSHIP TO SUBSCRIBER:** _____

EMPLOYER: _____ **PHONE #** _____

EMPLOYER ADDRESS: _____

SUBSCRIBER SOCIAL SECURITY # _____ **DATE OF BIRTH:** _____

INSURANCE ID # _____ **PLAN / GROUP #** _____

It is the patient's responsibility to pay deductibles, co-Insurance / co-pays on the day of service, and to pay any other balance not paid for by Insurance. If we are filing your claim, we will allow forty-five days from the filing date for the carrier to process your claim and make payment. If an insurance payment is not received within this time frame, we will notify you to clear your account. Insurance filing is done as a courtesy to you and does not dismiss your responsibility to pay fo services. Self-pay patients must pay for services the day on which they are rendered. ***I understand that I am financially responsible for all charges whether or not paid by an insurance carrier.*** I hereby authorize said assignee to release all information neccessary to secure payment. This assignment applies to all charges outstanding as the date of signature and will remain in effect for all current and future charges until revoked in writing. A photocopy of this assignment is to be considered as valid as the original. Should the account be referred to as attorney for collection the undersigned shall pay reasonable attorney's fees & collection expense.

SIGNATURE _____ **DATE:** _____

PARENT (in minor) _____ **DATE:** _____