

Performance Therapeutics

Patient Information Form

Name:		Date:	
Address		Apt.#	
City:	Zip:	Home Phone #:	
State:		Work / Cell Phone #:	
SS#:		Birth Date:	Age:
Driver's License #:	State:	Marital Status: S M D W	
Sex: M F	Retired: Y N	Disabled: Y N	Race:
Employer:			
Employer's Address		City:	State: Zip:
Spouse's Name			
Spouse's SSN		Birthday:	
Spouse's Employer		Phone:	
Emergency Contact:		Phone:	
I was referred to Performance Therapeutics by:			
Insurance Holder / Financially Responsible Party		Please present Ins. Card to Receptionist	
Name:		Date:	
Address		Apt.#	
City:	Zip:	Home Phone #:	
State:		Work / Cell Phone #:	
SS#:		Birth Date:	Age:
Driver's License #:	State:	Marital Status: S M D W	
Sex: M F	Retired: Y N	Disabled: Y N	Race:
Employer:			
Employer's Address		City:	State: Zip:

FamilyCare Billing Policy

FamilyCare Specialists files insurance only for selective HMOS and PPOs (see Receptionist for specific companies). Any co-payments, deductibles and/or coinsurance will be the patient's responsibility. If you are not covered by one of these companies, payment in full will be expected at the time of service unless prior arrangements have been made. Any necessary information you may need to file for reimbursement will be provided.

I hereby agree to the policy above and authorize FamilyCare Specialists to provide me (or my child) with medical care. I authorize FamilyCare Specialists to release medical information to my Insurance Company, if necessary, to process a claim.

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for other services rendered, including reasonable attorney's fees and costs of collection in the event of a default.

Patient Signature / Child's Name (Minor)

Date

Signature of Parent or Guardian

Date