

PHYSICIAN: _____ REFERRED BY: _____ DATE: _____

Patient Information

Patient Name: Last			First	MI	Phone ()	Cell ()
Address				Birth Date	Social Security Number	
City		State	Zip Code		<input type="checkbox"/> Single	<input type="checkbox"/> Widowed
					<input type="checkbox"/> Married	<input type="checkbox"/> Divorced
Patient Employer				Occupation	Phone ()	
Address						
City		State	Zip Code		Drivers Lic. #	
Spouse Name: Last			First	MI	Phone ()	Cell ()
Address						
City		State	Zip Code		Drivers Lic. #	
Spouse Employer				Occupation	Phone ()	
Address						
City		State	Zip Code			
Emergency Contact (Not in Household) Last			First	MI	Relationship	Phone ()
						Cell ()

Insurance Information (Primary) Insurance Information (Secondary)

Insurance Company:			Insurance Company:		
Policy Number	Group Number	Misc Number	Policy Number	Group Number	Misc Number
Subscriber Name: Last		First	MI	Subscriber Name: Last	
Address			Address		
City		State	Zip Code	City	
Birth Date / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone ()	Birth Date / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone ()

MEDICARE PART B "ONE TIME AUTHORIZATION AGREEMENT" STATE TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS, AND PATIENT.

"I REQUEST THAT PAYMENT OR AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF FOR ANY SERVICES FURNISHED TO ME BY THIS PROVIDER. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS FOR RELATED SERVICES.

PAYMENT TO PROVIDER

X _____
PATIENT'S SIGNATURE PROVIDER

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION AND STATEMENT OF FINANCIAL RESPONSIBILITY.

"I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIM(S) FOR THE PAYMENT OF BNEEFITS EITHER TO MYSELF OR GRAND VALLEY INTERNAL MEDICINE SPECIALISTS, P.C."

"I FURTHER AGREE TO ASSUME FINANCIAL RESPONSIBILITY FOR THESE SERVICES AND WILL PAY TO GRAND VALLEY INTERNAL MEDICINE SPECIALISTS, P.C., TO THE FULL EXTENT LEGALLY DUE THEM, ANY AMOUNTS NOT PAID DIRECTLY TO THEM BY MEDICARE, BLUE SHIELD, OR OTHER INSURANCE COMPANY."

X _____
PATIENT OR RESPONSIBLE PARTY SIGNATURE

Acknowledge of receipt

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she received a copy of the Grand Valley Internal Medicine Specialists, PC's Notice of Privacy Policies on the date indicated below.

Date: _____ Signature _____

Name of Patient

If this acknowledgement is not signed by the patient, please print the information set forth below: