

PATIENT IDENTIFICATION

			Male	Female	
Patient Last Name	First	Middle Initial	Sex	Birth Date	
		City	State	Zip	
	Home Phone	Cell Phone	Work Phone		
	Work Address		Occupation		
		Relationship to Patient	Contact Phone #		
	Spouse Name (if married)	All other names patient has used, including maiden name			
	Work Address		Work Phone		
Other Family Members Living With You (Names and Ages)					
	Pastor/Priest/Rabbi/Other Spiritual Leader		I was referred here by		

List medications patient is allergic to: _____

INSURANCE INFORMATION Please present your insurance identification card(s) or letter to the receptionist.

- Single Married (Marital Status is required for insurance claims – please check one)
- Medicaid. My caseworker's name is: _____
- Medicare. Please complete the Medicare Authorization and Medicare Secondary Payer Questionnaire on the other side.
- Group or Private Health Insurance. Policyholder _____ Policyholder Birth Date _____
- Today's visit is the result of a work injury. Employer authorizing treatment: _____
- No insurance. I am personally responsible for payment of my medical bills.

BILLING INFORMATION Payments are due at the time of service. Insurance copayments not paid on the day of service are subject to a billing fee. Notify the receptionist if you have any questions.

Complete the following section if someone other than the patient is responsible for payment. For adults, you or your spouse can be the Responsible Party. For patients under 19, the Responsible Party must be a parent or legal guardian with whom the child lives. No one else can be the Responsible Party unless they give their written consent.

Responsible Party Last Name	First	Middle Initial	Relationship to Patient		
		City	State	Zip	Home Phone
	Work Address		Occupation		Work Phone

ACKNOWLEDGEMENT and AUTHORIZATION

I acknowledge that I have received a copy of Lincoln Counseling and Enrichment's Notice of Policy Practices. I authorize the release of any medical information necessary to process my insurance claims. I authorize payment of benefits to Lincoln Family Medical Group, P.C. if my provider participates in my insurance plan. If LFMG does not participate in my insurance plan, I take responsibility for payment of all fees for services received. I understand that payment of the portion of the bill for which I am responsible is due at the time of each visit.

Signature of patient (parent or legal guardian if patient is a minor)

Date