Patient Demographic Information

PLEASE FILL OUT FORM COMPLETELY

Date: _____

Patient Information	**Guarantor Information (Person responsible for Account)**
Last Name: _____	Last Name: _____
First Name: _____ Middle: ___	First Name: _____ Middle: ___
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Home phone: _____	Home phone: _____
Cell phone: _____	Cell phone: _____
Social Security No: _____	Social Security No: _____
Date of Birth: _____ Sex: _____	Date of Birth: _____ Sex: ____
Married/Widowed/Single/Child: _____	Relation to patient: _____
Employer: _____	Employer: _____
Employer phone: _____	Employer phone: _____

If patient is a minor, does minor live with both parents or one parent? _____

Emergency Contact Info:

Name: _____ Relation: _____

Phone: _____

BILLING/INSURANCE INFORMATION

Please check applicable below:

_____ Private (No Insurance) **Cash or payment arrangements must be made.**

_____ Primary Insurance: _____

_____ Secondary Insurance: (if applicable) _____

PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST SO THAT WE MAY COPY IT. IF YOU DO NOT HAVE YOUR CARD WITH YOU, PLEASE PAY FOR YOUR VISIT AT TIME OF SERVICE. **(OVER ----→)**

AUTHORIZATION POLICY

I authorize Dr. Cox/Selah Medical Center to provide all treatment deemed medically necessary.

CREDIT POLICY

We bill your insurance company for you. However, you are responsible for the total balance due. Any disputed claims are between you and your insurance company. We will be happy to provide your insurance company with any information that is needed to process your claim. Co-payments are the patient's responsibility and are due at every visit. We will not carry large outstanding balances. A payment plan may be pre-approved by the office manager or billing manager. Current insurance cards are to be provided at the time of service. If you belong to an insurance plan that assigns a specific physician, it is your responsibility to ensure that William T. Cox, D.O. is assigned as your primary physician. If you have been assigned to another physician, it is your responsibility to contact your insurance carrier and have your primary physician changed to Dr. Cox prior to your appointment. If this is not done prior to your appointment, the insurance company will not pay for your visit, and you will be billed privately for the cost of the visit.

NO SHOW POLICY

There will be a $50 charge if for any reason you miss more than one appointment or fail to give us 24-hour notice of cancellation. If you fail to make your appointment 3 times under our care, your chart will be reviewed to determine if we will continue to provide your health care.

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS

I hereby authorize and assign to Selah Medical Center and/or Dr. William T. Cox, all insurance and other benefits otherwise payable to me, but not to exceed the physician's regular charges for services rendered.

I understand that I am financially responsible for charges not covered by this assignment and agree to pay the physician in accordance with his/her regular rates and terms. I agree that payment for services rendered to me is due at the time of my visit. I agree, that if the account is referred to an attorney or agency for collection, to pay reasonable attorney fees and collection expenses. The venue of any legal action to collect an account shall lie in Yakima County.

I HAVE READ THE CREDIT POLICY AND WITH MY SIGNATURE I ACCEPT THESE TERMS.

_____ _____

Signature of patient or guardian Date