FOR PROVIDER USE ONLY:
PRIVACY PRACTICES ACKNOWLEDGEMENT

SIGNED_____

David D. Van Slooten, M.D., P.A.
Lorraine S. Lira, M.D.
Patricia G. Klein, M.D.

PATIENT DATA FORM

PLEASE PRINT YOUR NAME AS IT APPEARS ON YOUR INSURANCE ID CARD

NAME_____ DATE OF BIRTH _____

SEX: MALE/FEMALE RACE _____ MARITAL STATUS _____ SOCIAL SECURITY# _____

PREF. LANGUAGE _____ EMAIL ADDRESS:_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

PRIMARY TELEPHONE NUMBER _____ HOME OR CELL

SECONDARY TELEPHONE NUMBER _____ HOME OR CELL

EMERGENCY CONTACT NAME AND PHONE#: _____

LOCAL PHARMACY NAME AND ADDRESS_____

_____PHONE #:_____

MAIL ORDER PHARMACY (EXACT NAME)_____

EMPLOYER NAME:_____ ADDRESSS_____

CITY_____ STATE_____ZIP CODE_____

WORK # _____OCCUPATION_____

NAME OF YOUR REFERRING DOCTOR:

NAME: _____

IF NO REFERRING DOCTOR PLEASE PROVIDE YOUR PRIMARY DOCTOR:

NAME #: _____

INSURANCE INFORMATION:

PRIMARY CARRIER NAME: _____

Insured Policyholder Name/DOB: _____

SECONDARY CARRIER NAME: _____

I VERIFY THE ACCURACY OF THE ABOVE INFORMATION AND I REALIZE THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF BILLS INCURRED.

PATIENT'S SIGNATURE_____**DATE**_____

CREDIT CARD PAYMENT INFORMATION

PATIENT NAME _____ **DATE** _____

PRIMARY INSURANCE PLAN _____ **ID #** _____

I authorize that any applicable medical fees can be processed to my credit/debit card information as provided below for outstanding balances, Co-Pays, Co-Insurance, Deductibles, Tests and Office Visits up to the Allowed Amount which my insurance has not covered. I will receive a courtesy telephone call prior to the credit card transaction and will receive a mailed receipt.

CREDIT CARD (circle one) **VISA** **MASTERCARD**

CREDIT CARD NUMBER _____ **EXPIRATION DATE** _____

3 DIGIT CVC CODE ON BACK OF CARD _____

PATIENT'S SIGNATURE _____ **DATE** _____

****

MISSED APPOINTMENTS

We would like to advise you that there will a charge for missed appointments as indicated below:

OFFICE VISITS – If 24-hour notice is not given, a fee of $25.00 will be charged.

TESTING (i.e. EMG, EEG, Neuro-Trax and Ultrasound) – If 48 hour notice is not given, a fee of $100.00 will be charged.

If you fail to cancel in time or fail to show up, there will be a fee, as above, for the missed appointment.

PATIENT'S SIGNATURE _____ **DATE** _____