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______________

FINANCIAL POLICY

Our commitment is to provide the very best medical care to our patients while recognizing the need to limit services to only those that are necessary for each patient. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's healthcare and financial arrangements for that medical care. Your clear understanding of our financial policies is important to our professional relationship. Please contact your insurance company regarding coverage and financial responsibilities. Please contact our billing office regarding any questions about our fees and financial policies.

PROFESSIONAL FEES: Our fees for medical services are comparable to other similarly trained physicians in the community and reflect the complexity of your specific needs, the physician time dedicated to your care, the specialized nature of the doctor's education and training and support of costs associated with providing and coordinating your care. We also provide telephone appointments to help with your chronic healthcare needs (Covered by most insurance).

PATIENT PAYMENTS: Co-pays, Co-insurance, deductibles, services not covered by your insurance plans or outstanding balances are due at the time of your appointment. Payments may be made with cash, check or credit card. Returned checks will be subject to the fee allowed by state regulations. Please let us know if you are having a particular financial problem prior to your scheduled appointment and we will try our best to be understanding.

ADDITIONAL FEES: Missed Appointments: Please understand that when you reserve an appointment with one of our physicians, we are making a commitment to your medical care and this prevents another patient from receiving care at that time. To assist all of our patients with appropriate access to our physicians we may charge a fee for any office visit appointment cancelled with less than 24 hours' notice. Please note this fee is not covered by your insurance company. Medical Forms: The completion of disability forms, attending physician statements and other supplemental insurance forms all require physician and staff time to complete. Accordingly, a fee may be charged to complete most of these forms. Non-standard forms may be higher. Medical Records: applicable fees apply.

We will be happy to provide you with additional information at any time.

______________________________ ______________________

Signature of Responsible Person Date

CREDIT CARD PAYMENT INFORMATION

I authorize that any applicable medical fee 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 NUMBER ______________________ **VISA**______ **OR MASTERCARD** _______

3 DIGIT CVC CODE ON BACK OF CARD ______________ **EXPIRATION DATE** __________

PATIENT'S NAME (PRINT) ______________________________

PATIENT'S SIGNATURE ______________________________ **DATE** __________