EPE, LLC

PATIENT INFORMATION FORM

Last First MI GENDER

Name: _____ [ ] Male [ ] Female

LOCAL

Address: _____ APT: _____ Social Security: _____

Birth Date: _____

City/State/Zip _____ **Marital Status:**[ ]Single [ ]Married [ ] Widower [ ] Divorced

Email: _____ Employment: [ ]Full Time [ ]Part Time

[ ]Self Empl [ ]Retired

Out of State or Country: _____ Home Phone: _____

Address: _____ Work Phone: _____

Primary Doctor's Name: _____ Cell Phone: _____

Telephone: _____ Other Phone: _____

Emergency Contact Name: _____ **Emergency Contact Phone:** _____

Best way to communicate with you: [ ]Email [ ]Home Phone [ ]Work Phone [ ]Cell Phone

Insurance Information

Primary Insurance Carrier: _____ Effective Date: _____

Policyholder's Name: _____

Relationship to patient: [ ]Self [ ]Spouse [ ]Parent

Secondary Insurance Carrier: _____ Effective Date: _____

Policyholder's Name: _____

Relationship to patient: [ ]Self [ ]Spouse [ ]Parent

Please give your insurance cards and ID to the receptionist for scanning- Thank You

Assignment of Insurance Benefits and Autorization to Release Medical Information

I hereby authorize the payment of benefits of my insurance policy, if any, to be paid directly to **EPE, LLC** for professional services rendered. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services.

I further authorize the release of any medical information required by my insurance carrier and the release by the hospital and the aforesaid doctors, in their discretion, of my x-ray films, laboratory findings and records to other hospitals and physicians upon their request.

I also authorize _____Relation to patient_____to obtain on my behalf copies of my medical records or speak with my physician regarding my care. I can revoke this authorization, in writing, at any time.

I understand that I am financially responsible for charges not paid by my insurance. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.

Signature of Patient / Legal Guardian: _____ Date: _____

PLEASE BE ADVISED THAT A COPY OF THE DOCTOR'S NOTE IS AVAILABLE UPON REQUEST