*PATIENT INFORMATION *

Last Name: _____ First Name: _____ Middle Initial: _____

Home Address: _____ Apt. #_____ City: _____ State: _____ Zip: _____

Home Telephone: (_____)_____ Cell Phone: (_____)_____ Male/Female Marital Status: S/ M /D /W /Sep

Drivers License #_____ Expires: _____ SS#:_____ Date of Birth:____/____/_____ Age:_____

* PRIMARY INSURANCE COVERAGE *

Name of Primary Insurance Company: _____

Name of Person Who Carries the Primary Insurance: _____ Date of Birth: _____/_____/_____

His/Her Address: _____ City _____ State: _____ Zip:_____

His/Her Home Telephone: (_____)_____

*EMPLOYER: of person who carries the insurance *

Employer Name: _____ Company Telephone: (____)_____

Employer Address: _____ City: _____ State:_____ Zip: _____

Position / Occupation of person who carries the insurance: _____

SECONDARY INSURANCE COVERAGE

Name of Secondary Insurance Company: _____

Name of Person Who Carries the Secondary Insurance: _____ Date of Birth: ____/____/_____

His/Her Address: _____ City _____ State:_____

Zip:_____ His/Her Home Telephone: (_____)_____ His / Her SSN # _____

Nearest Relative (Not living with you)

Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship: _____ His/Her Home Telephone: (_____)_____

* PERSON RESPONSIBLE FOR PAYMENTS NOT COVERED BY INSURANCE * *Check If Same As Patient:* ☐

Last Name: _____ First Name: _____ Date of Birth: _____/____/_____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: (_____)_____ His / Her SSN #:_____ Relationship to Patient: _____

* Assignment of Benefits *

I hereby authorize the doctor and his/her designees to release all information necessary to secure the payment of my insurance benefits. I directly assign all medical /surgical benefits to SeaPointe Medical Group. *I understand that I am financially responsible for payment of all chargers whether or not paid by my insurance as per the SeaPointe Medical Group.* I further agree that a photocopy of this agreement shall be as valid as the original.

Signed: _____ Print Name: _____ Date: _____

Treatment of a Minor:

I authorize SeaPointe Medical Group to treat_____ a Minor in my care. I am the patient's PARENT / GUARDIAN / other: _____
Name of minor

Signed_____ Print Name: _____ Date:_____

Payment Policy

It is policy of *SeaPointe Medical Group* to receive payment in full at the time service rendered unless other arrangements have been made in advance. If you wish our office to bill an insurance company, a copy of your insurance card and/or complete billing information is required and must be presented before services are rendered. Due to the different types of insurance plans and benefits: enrollment in an insurance plan is not a guarantee of full payment for services rendered. Deductibles, co-payments and other "patient responsibility" amounts are due at the time of service.

SeaPointe Medical Group does not and cannot assume responsibility for verification of insurance benefits and or coverage. Please contact your insurance company to verify your benefits and doctor participation in you insurance plan before services are rendered, as this will determine your portion of the bill. This also applies to any facility or provider that our doctor may refer you to.

Depending on your insurance company, your type of medical coverage (HMO, PPO etc.) and/or your benefit plan (80/20, 90/10, co-pay, deductibles etc.) The insurance company may not pay any of the bills, or pay only a portion of the bill for reasons including but not limited to: patient co-pays, patient's deductibles, non- covered services, reduced payment for services, services deemed by the insurance plan. ANY PORTION OF THE BALANCE NOT PAID BY THE INSURANCE COMPANY FOR ANY REASON IS THE RESPONSIBILITY OF THE PATIENT, OR THE PERSON LISTED AS THE RESPONSIBLE PARTY.

A statement of charges will be sent to the patient or reasonable part each month showing the portion billed to the insurance company and the patient due balance. Patient due balances over sixty days old will be subject to late fees. Delinquent balances may be referred to an outside agency for collections.

I have read the above policy and understand that I am financially responsible for all medical services rendered.

_____ _____

Signature of Patient or Responsible Party Date

_____

Print Name

PF-2000 **Acknowledgement of receipt of Notice of Privacy Practices.**

SeaPointe Medical Group reserves the right to modify the privacy practices Outlined in the notice.

I have reviewed a copy of the Notice of Privacy Practices for *SeaPointe Medical Group*

_____ _____

Patient's or Patient Representative's Signature (Date)

_____

Print Patient's Name

_____

(If Representative, Print Name and Relationship to Patient)

May we leave confidential information on your answering machine/voicemail (lab results, etc.)?

YES **NO**

Is there anyone you would like us to be able to share information with if you are unavailable when we call?

YES **NO**

IF Yes, please designate who we are allowed to share your information with:

_____

SEA POINTE MEDICAL GROUP INC.

Cancellation Policy

We make every effort to accommodate your request for appointment times. We schedule a limited number of patients so that Dr. Gentile and Dr. LaMotte may spend an adequate amount of time with each patient. We commit this appointment to you, and we do not double booking your appointment time. As a courtesy, we attempt to call every patient in advance to confirm the upcoming appointment. ***However, our cancellation policy requires that if you do not cancel your appointment 24 business hours in advance, we must charge a cancellation fee of $35 for a routine visit and $75 for a physical.***

Patient Signature_____
Date_____

Lab Policy

Please be aware that unless you get a call from our office or have an appointment scheduled for a follow-up, you must call for results of your test including but not limited to blood work, pap smears, x-rays and all other diagnostic tests. This will assure us that all test we ordered are received by our office

Thank You.

Patient Signature _____
Date_____