

PLEASE NOTE – THIS FORM MUST BE COMPLETED IN FULL

Last Name _____ First _____ Middle _____

Street Address _____

City _____ State _____ Zip _____

Date of Birth _____ Social Security Number _____

Home Phone _____ Work _____ Cell _____

Sex M F _____ Marital Status S M D W _____

Emergency Contact:

Name _____ Street Address _____

City, State, Zip _____

Home Phone _____ Work _____ Cell _____

PERSON RESPONSIBLE FOR PAYMENT OF BILL

Self Spouse Parent Guardian Other _____

If you are not responsible for payment please complete below:

Name of Responsible Party _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Social Security Number _____ Sex M F _____

Home Phone _____ Work _____ Cell _____

Employer Name _____ Street Address _____

City, State, Zip _____

ALL PATIENTS MUST SIGN THIS AUTHORIZATION TO RELEASE RECORDS

I request payment of authorized insurance benefits by one or more private or public health benefits program which I designate to pay for my care, to be made either to me or on my behalf to NPFMA for any services furnished to me by NPFMA physicians and/or other health professionals. I authorize those holding records of my medical care to release copies of them or information from them to (a) my health benefits program(s) or its/their authorized representative as needed to obtain payment for services rendered, or (b) to other healthcare providers to whom I am referred to for further care.

Signature _____ Date _____

MEDICARE AND SUPPLEMENTAL INSURANCE ONLY

I request that payment of authorized Medicare benefits be made either to me or on my behalf to NPFMA or _____ for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature _____ Date _____