

EAST GRANBY FAMILY PRACTICE INSURANCE UPDATE SHEET

IMPORTANT: Please select and circle your Primary Care Physician

Dr. Ewald
Dr. Freedman

Dr. Howlett
Dr. Reiher

Dr. Lerner

Dr. Ghumman
Dr. Pursnani

PATIENT INFORMATION

Please Circle:

Name _____
 Address _____
 Town _____
 State _____ Zip _____
 SSN _____ - _____ - _____
 Employer _____
 Language English Spanish French Other _____

Sex: Female Male
 Marital Status: Single Married Widowed Divorced Separated
 Date of Birth _____ / _____ / _____
 Patient Home () _____
 Patient/Parent Work () _____
 Patient/Parent Cell () _____

PHARMACY INFORMATION

Name _____
 Town _____
 Pharmacy Phone/Fax # () _____

Please circle preferred number - Home Work Cell
 E-Mail _____
 Emergency Contact _____
 Contact Phone # () _____
 (preferably outside household)

If this information is not completed IN FULL, your claim may be denied by your insurance company, and become your responsibility. We destroy the previous sheet, old information is not transferable. PLEASE COMPLETE!

INSURANCE INFORMATION	PRIMARY	SECONDARY
INSURANCE CO.	_____	_____
ID #	_____	_____
GROUP #	_____	_____
SUBSCRIBER INFORMATION		
Subscriber Name	_____	_____
Subscriber SSN	_____ - _____ - _____	_____ - _____ - _____
Subscriber DOB	_____ / _____ / _____	_____ / _____ / _____
Subscriber is:	Self Spouse Parent	Significant Other other (specify)

PATIENT RESPONSIBILITIES

To assist our patients to understand their financial responsibilities to the practice and additional charges that may be applied to non-payment, missed appointment, cancelled appointments, etc., please note the following:

- ▶ I agree to pay **\$50.00** fee for any appointment missed or if I fail to notify the office **24 hours** in advance.
- ▶ If I fail to pay my co-payment at time of my appointment, I agree to pay a **\$10.00** billing charge.
- ▶ In divorce cases, remember that the adult seeking treatment is responsible for the bill regardless of their own personal problems. If the court has awarded custody of minor children to one person and financial responsibility to another, **the person bringing the child is responsible for payment of those services at the time of their visit.** A receipt can be provided should you wish to bill your estranged.
- ▶ I agree to pay **\$25** fee for any check that is returned by my bank.
- ▶ If I fail to pay my bill in a satisfactory manner within 60 days and the account is assigned to a collection agency, I will pay the costs of a one time collection fee of **\$25.00**. If required I will also be responsible for attorney's fees.
- ▶ I understand that the office can only bill for a diagnosis documented in my record, and that to ask the doctor to change a diagnosis to secure insurance payments constitutes fraud.
- ▶ We ask that each of our patients now take the responsibility of knowing what their specific health benefits are. Our office will continue to submit insurance claims as a courtesy to our patients. However, we regret that we can no longer commit to knowing what each insurance company will pay on any given procedure.

AUTHORIZATION AND RELEASE: I hereby authorize payment for any services on my behalf be made directly to the doctor. I understand that I am responsible to the doctor for charges not covered by my insurance company. I hereby authorize my physician to release any information required to support my claim, treatment, health care operations and for other purposes that are permitted or required by law.

 Patient's Signature or Legal Guardian (Specify relationship to patient) _____
 Date

Do you have an advanced directive/living will? (please circle) YES NO
 If yes, please provide a copy to the doctor.