

ancock Physician Network

Name:	Sex:	Birthdate:	Age:
Address:	Apt #	Marital Status:(circle one) Single Married Other	
City:	State:	Zip:	Occupation:
Social Security #	Employer:		
Home Phone: ()	Student: (circle one) Full Time Part Time		
Work Phone: ()	School Name:		
Cell Phone: ()	Patient email address:		

Person Responsible for Payment (If different from patient)

Name:	Relationship to Patient:		
Address:	Social Security:		
City:	State:	Zip:	Employer:
Home Phone: ()	Employer Address		
Work Phone: ()	City:	State:	Zip:
Cell Phone: ()			

In Case of Emergency Please Notify:

Name:	Relationship to Patient:
Phone:	

**** You must provide our office with a copy of your Insurance card/cards. We will not file Insurance without a copy of your card.****

Primary Insurance Policy:

Secondary Insurance Policy:

Insurance Company Name:	Insurance Company Name:
Enrollee Name:	Enrollee Name:
Enrollee's Social Security #	Enrollee's Social Security #
Enrollee's Date of Birth:	Enrollee's Date of Birth:
Enrollee's Employer	Enrollee's Employer

Please list names & Birthdates of those living in same household

Name:	DOB:	Name:	DOB:
Name:	DOB:	Name:	DOB:
Name:	DOB:	Name:	DOB:

Please list Anybody that we are authorized to discuss your medical or financial records with:

Medical Only:	Initial _____
Financial Only:	Initial _____

***** Please provide signature on back of form *****

AUTHORIZATION TO RELEASE AND OBTAIN MEDICAL INFORMATION: I hereby authorize this office to release any information acquired to establish a health insurance claim. I authorize this office to obtain previous medical records from other physicians and /or medical facilities.

I hereby authorize this office to release information regarding treatment of drug or alcohol abuse, psychological conditions, HIV testing or an AIDS related condition to establish a health insurance claim.

I hereby authorize Hancock Physician Network to apply for benefits on my behalf for services rendered by him/her, or his/her order. I request that payment from my insurance company or Medicare and Medigap be made directly to Hancock Physician Network (or the party who accepts assignment). I understand that I am responsible for all unpaid charges.

I understand that all charges are to be paid at the time of service unless I present a valid insurance card that represents an insurance carrier with which Hancock Physician Network has contractual agreement. All deductibles, co-pays, and non-covered services are expected to be paid at the time of service. If my account is turned over to an outside collection agency, I will be responsible for my balance plus any legal fees or collection fees involved.

In the case of children whose responsible party is someone other than the custodial parent, we must ask that the person accompanying the child to the office make payment at the time of service. Although we empathize with the problems of divorcing parents, we cannot become involved in the financial arrangements of the divorce decree.

It is your responsibility to notify your insurance company of an impending hospital or surgical admission.

INSURANCE DATA

1. We need to copy your ID card
2. Does your insurance require precertification? Yes No
3. Does your insurance require a second surgical opinion? Yes No

Name of laboratory insurance is contracted with _____

All labs will be sent to Hancock Regional Hospital (HRH) unless we are otherwise informed. Hancock Physician Network is not responsible for charges resulting from labs being sent to an incorrect lab.

Patient's Initials: _____

I have received Hancock Physician Payment Policy.

Signature: _____
(Of patient or patient's legal guardian)

Date: _____