

**MEDICARE BILLING INFORMATION**

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**PATIENT INFORMATION**

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

HOW WOULD YOU LIKE TO BE ADDRESSED? (first name, Mr., Mrs., etc.) \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX (please circle): Male Female

MARITAL STATUS (please circle): Single Married Widowed

PHONE #: Home: (\_\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_\_) \_\_\_\_\_ Cell:(\_\_\_\_\_) \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

WHO CAN WE CONTACT IN CASE OF EMERGENCY? Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

DO YOU GIVE OUR OFFICE PERMISSION TO DISCUSS YOUR MEDICAL INFORMATION WITH FAMILY MEMBERS?  YES  NO IF YES, PLEASE PROVIDE THEIR NAMES AND PHONE NUMBERS BELOW.

NAME: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE # \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE # \_\_\_\_\_

HOW DID YOUR HEAR OF OUR OFFICE?  Friend or family member? \_\_\_\_\_  
 Phone book  Website  Dr. referral  Other \_\_\_\_\_

WHO IS YOUR FAMILY PHYSICIAN?(first and last name please) \_\_\_\_\_

**BILLING INFORMATION**

RESPONSIBLE PARTY (excluding insurance): \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ RELATIONSHIP TO PATIENT:  Parent  Spouse  Legal Guardian

MAILING ADDRESS (if different from above): \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**INSURANCE INFORMATION** DO YOU HAVE HEALTH INSURANCE?  YES  NO  
IF YES, PLEASE PRESENT YOUR CARD(S) TO THE RECEPTIONIST TO TAKE A COPY. (PLEASE BE AWARE THAT IF WE DO NOT HAVE CURRENT INSURANCE INFORMATION WE WILL BE UNABLE TO BILL YOUR CLAIM.)

PRIMARY INSURANCE: \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_

NAME OF INSURED: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

**PLEASE SEE OTHER SIDE**

According to the Centers for Medicare and Medicaid Services, a provider is to bill a Medicare beneficiary for his/her yearly deductible and coinsurance. In addition, a provider may bill Medicare beneficiaries for non-covered services and services that are considered to be not medically necessary as long as an Advanced Beneficiary Notice has been signed by the patient.

I agree that I am financially responsible for charges as outlined above. I am aware that if I do not provide current insurance information Dr. Swinyer's office will be unable to bill my claim.

I understand that in the event that I cannot make a scheduled appointment I must cancel at least 24 hours prior to that appointment time. Failure to do so will result in a \$50.00 charge to my account (per incident). This fee is not billable to Medicare.

In the event that full payment for the above charges is not made, I agree to pay all cost of collection, including Collection Agency Commission and reasonable attorney's fees. I also agree to submit myself to the jurisdiction of the courts of Salt Lake County, Utah.

I consent to medical treatment as provided by Leonard J. Swinyer, M.D., P.C.

This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment will be considered as valid as an original.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(Responsible Party)

I have received a copy of the Notice of Privacy Practices for Leonard J. Swinyer, M.D., P.C.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(Responsible Party)