Steven R. Bullard, MD, PC

Patient Name_____ Date of Birth_____ Sex: M F

Primary Insurance _____ ID#_____Group#_____

Secondary Insurance _____ ID#_____Group#_____

Name of Policy Holder_____ Policy Holder DOB_____
(If different from patient)

Relationship to Patient: _____Policy Holder's Social Security #_____

Policy Holder's Home Address_____

_____

Home Phone _____ Work Phone_____ Cell Phone_____

I authorize any holder of medical or other information about me to release to my insurance carrier in order to settle my insurance claim.

I authorize payment of medical benefits to Steven R. Bullard, MD, for services provided. I agree to pay in full any balance due for services that are deemed to be my responsibility. This may include services denied by my insurance as non-covered, applied to my deductible, part of my coinsurance, etc. If I fail to pay in a timely manner, I understand that my account may be sent to a collection agency. I agree to be financially responsible for any collection fees incurred.

I understand that it is my responsibility to provide Steven R. Bullard, MD, with my current insurance card and a valid referral that my insurance requires at the time services are rendered. If I cannot provide my current insurance card and/or referral, my appointment may be rescheduled. If I choose to keep the appointment, I will be financially responsible for any fees incurred.

I understand it is my responsibility to know the correct amount of my co-payment that is due and payable on the day of service. There is a $10.00 billing fee each time a bill is generated for all co-pays not paid at the time of service.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Printed Name

*** *THIS FORM IS VALID FOR ONE YEAR UNLESS THERE IS A CHANGE IN INSURANCE* ***