

Colorado Springs Family Practice

Please print all requested information.

PATIENT INFORMATION

Name: _____ Date of Birth: ____ / ____ / ____ SSN: ____ - ____ - ____
Gender: M or F Marital Status: Single Married Divorced Widowed Legally Separated
Address: _____ City/State: _____ Zip Code: _____ County: _____
Home Phone:(_____) _____ Employer: _____
Work Phone:(_____) _____ Occupation: _____
Cell Phone:(_____) _____ Work Address: _____
E-Mail Address: _____ State: _____ Zip Code: _____
Race(optional): Asian Native Hawaiian Other Polynesian Black Native American White Unknown
Ethnicity: Hispanic All Others Language Preferred: _____

INSURANCE INFORMATION (if applicable) Payments including co-payments are due and collected at your scheduled appointment

Primary Insurance: _____ Secondary Insurance: _____
Policy/Id #: _____ Group#: _____ Policy/Id #: _____ Group #: _____
Policy Holder's Name: _____ Policy Holder's Name: _____
Policy Holder's DOB: _____ Policy Holder's DOB: _____
Policy Holder's SSN: _____ Policy Holder's SSN: _____
Relationship to Patient: _____ Relationship to Patient: _____

EMERGENCY CONTACT (nearest relative not living with you)

Name: _____ Relationship: _____
Address: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

Financial Agreement, Authorization for Treatment, Release of Medical Information and Appointment Policy

I authorize treatment of the person(s) named above and agree to pay all fees and charges for such treatment. I understand this is payable prior to the time of service. As a courtesy, you will bill my insurance company, but will collect any co-pay or deductible due at the time of service. I authorize payment of insurance benefits directly to Colorado Springs Family Practice. I hereby authorize release of medical information needed to complete insurance claim inquiries. I am also aware that if insurance does not cover services within 45 days, interest will be assessed at the rate of 1.5% per month on the unpaid balance. I am responsible for all charges including costs for collection, attorney fees and court costs. Insurance benefits are a matter between you and your insurance company. You are ultimately responsible for payment on your account. A 24 hour notice is requested for changing or cancelling an appointment. "No Show" missed appointments are subject to a \$40.00 fee, as the appointment was a specific time set aside specially for you.

Signature: _____ Date: _____