

WELCOME TO NORTH STATE MEDICAL GROUP

As part of the intake process to establish you as a new patient, or to update our files for those who are established patients at our facility, the information on the reverse side needs to be completed in full. Please take the time to complete all the information, including the insurance section. For those of you who are already established patients, please bear with us, as this is required of us for each new calendar year.

In an effort to keep our fees down through controlling administrative costs, we have implemented the following payment policies:

- 1) All payments and co-payments are to be made at the time of your visit, unless prior arrangements have been made. We participate in most major insurance networks and we will bill the insurance company if you are a participant in one of the participating programs. **If you are not covered by one of these plans, you will be required to pay at the time of service**, unless special financial arrangements have been made with our billing department **prior to service**. Upon **full payment** for this service, you will be given insurance ready receipt in which you may file with your insurance company for reimbursement.

Accepted methods of payments by this office include:

***Cash, Money Order, Cashiers check**

***Local-personal checks with proper picture ID**

***Visa and MasterCard with proper picture ID**

***There will be a \$25.00 service fee for all returned checks!**

- 2) INSURANCE: While we try to help in any way possible, please remember that insurance is a contract between you and your insurance provider. YOU, therefore, are ultimately responsible for your medical bills. Any changes billed to insurance for services performed at our facility which remain outstanding for more than 60 days, will become the responsibility of that patient or appropriate account Guarantor (in the case of a dependent child or adult). At this time, if you feel these charges have been unjustly denied by your insurance carrier, it is YOUR responsibility to contact your insurance carrier to appeal their decision.

If you have any questions concerning the payment policy, please ask PRIOR to being seen by the physician or nurse.

I, the undersigned, have read, understand, and agree to abide by the above policies of the North State Medical Group, PA.

Signature:_____Date:_____

North State Medical Group, PA

Name:(Last) _____ (First) _____ (MI) _____

Nickname: _____ Date of birth: _____

Gender: _____ SS#: _____ Marital Status: _____ Home Phone: _____

Cell Phone: _____ Other Phone Contact: _____

Mailing Address: _____ City: _____ Zip: _____

Street Address: _____ City: _____ Zip: _____

Spouse/Guarantor's Name: _____ Relationship: _____

HEALTH INSURANCE INFORMATION

Primary Insurance Company: _____ Group #: _____

Policy #: _____ Policy Holder's Name: _____

Relationship to Patient: _____ Policy Holder's DOB: _____ SS#: _____

Policy Holder's employer: _____

Secondary Insurance Company: _____ Group #: _____

Policy #: _____ Policy Holder's Name: _____

Relationship to patient: _____ Policy Holder's DOB: _____ SS#: _____

Policy Holder's employer: _____

Emergency Contact: Name:(Last) _____ (First) _____ MI: _____

Phone: _____ Alternate Phone: _____ Relationship: _____

Policy Holder's Employer: _____ Job title: _____

Phone: _____ ext: _____ Current Physician: _____ Phone: _____

How did you learn of North State Medical Group, PA? _____

I hereby authorize the release of any medical information necessary for the processing of insurance. I hereby assign all major medical and/or surgical benefits to which I am entitled under my current policy to be paid directly to North State Medical Group, PA as payment toward the total charges for professional services. I hereby authorize the carrier or attorney involved with my claim to pay directly North State Medical Group, PA on my behalf for the total charges for professional services I received as a result of my injuries. I agree to pay any balance of said services over and above the insurance payment. A photocopy of this assignment is to be considered as valid as the original. The assignment will remain in effect only for those charges designated to be billed to insurance and will remain until revoked by me in writing.

Signature of Insured: _____ Date: _____