Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_Today's Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First MI Last

Male\_\_\_\_\_ Female\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status: **S M D W (Please Circle)**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mailing Address City State Zip Code

Home Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Ethnicity/Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph : (\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph : (\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you require Interpreter Services other than Spanish? Yes\_\_\_\_\_ No\_\_\_\_\_ If YES-Language\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If Patient is a Minor, Responsible Party\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to the Patient? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRIMARY INSURANCE**

Name of Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Relationship to Patient: Self Spouse Parent Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Co: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Subscriber #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY INSURANCE**

Name of Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Relationship to Patient: Self Spouse Parent Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Co: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Subscriber #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE OF BENEFITS**

**I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. Emily Rekuc for medical services rendered to myself and/or my dependents. *I understand that I am responsible for any amount not covered by insurance in accordance with my insurance guidelines.***

***Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**AUTHORIZATION FOR TREATMENT**

I hereby consent to and authorize treatment, which in conjunction with the judgment of my attending physician, may be considered necessary and/or advisable for the diagnosis and/or treatment at Caring for Women, Dr. Emily Rekuc.

***Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

*Dr. Emily Rekuc reserves the right to modify the privacy practices outlined in the notice.*

**I have received a copy of the Notice of Privacy Practices for Emily Rekuc, DO.**

***Name of Patient*:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (**Please Print)**

***Signature of Patient/Parent if Minor***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­ ***Date***\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Policy and Insurance Information**

I understand and agree that insurance claim forms will be submitted to my insurance company but that I am ultimately responsible for all charges regardless of my existing medical coverage. I hereby give authorization for payment of insurance benefits to be made directly to Dr. Rekuc for services rendered. In the event that my insurance company forwards payment directly to me, instead of Dr. Rekuc, I will immediately deliver said payment to Dr. Rekuc. I understand and agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due, upon demand. I understand and agree that if it becomes necessary for Dr. Rekuc to utilize an outside collection agency or to commence court action, for the collection of any outstanding charges, I will be responsible for the outstanding balance (plus a $35 processing fee), and in addition, attorney fees, court costs and other expenses of litigation.

**Co-Payments**

Due to contractual obligations with your insurance company, all co-payments will be collected at the time of service. Co-payments are not billable and collection of co-payments is non-negotiable.

**Completion of Forms**

There is a charge for completing forms such as disability forms, DMV forms, or employer forms for various leaves. The Form Fee varies depending on the type of form however; the minimum fee is $25. The fee for this service is payable in advance of completing the form in ***cash only.*** ***Please allow 2-3 business days for completion of any form.***

**Dr. Rekuc’s Office Policy**

I have received a copy of Dr. Rekuc’s Office Policies and have a clear understanding of these policies and expectations. I read the no show/excessive cancellation portion and understand that if I no show to 3 appointments that our doctor-patient relationship will end and I will have to obtain a new physician.

I have reviewed and understand the above stated policies as indicated by my signature. By signing below, I am also stating that I am the person responsible for charges.

***Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***