- [ ] SELF PAY
- [ ] INSURANCE: ___________

DATE: ___________

PATIENT DEMOGRAPHICS

PATIENT NAME: ____ DOB: ____________________

ADDRESS: ____CITY: __________________________

STATE: ___________________ ZIP: _________________ PHONE: _____________________________

SSN: _________________ INSUREDS NAME: ___________________ INSUREDS DOB: _____________

Have you been seen here before? YES ☐ NO ☐

Yes☐ I have read and understand the HIPPA Privacy Statement that is attached to this clipboard. Assignment of Benefits: In exchange for Karas Health Care, (Hereinafter Provider) agreeing to pursue my insurance provider for payment of benefits due me for services, among and along with other valuable consideration, I, the undersigned patient, hereby irrevocably assign to the provider any and all medical payment benefits available under any insurance policy in which I may be entitled to as a result of, or related to the services rendered by the provider. If any language within the agreement is determined to be invalid or otherwise unenforceable, that the language shall be deemed void and the remainder of this agreement shall remain in full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

PRINT NAME: ____

SIGNATURE: ____ DATE: _______________

**** OFFICE STAFF ONLY **** **BILL INS. BILL PT. NO CHARGE CO-PAY PAID IN FULL SELF PAY NURSE VISIT DO NOT BILL PT.**

PREVIOUS BALANCE $ _______________

TOTAL AMOUNT DUE TODAY $________________

AMOUNT PAID $________________ #____________

V MC D AE CASH CHECK LTP PRISM

INS VERIFIED BY: ________ MA_____________ DATE: ____________________

NOTES: