

Date: _____

WELCOME TO THE BORN PREVENTIVE HEALTH CARE CLINIC, P.C. PLEASE COMPLETE THE FOLLOWING INFORMATION.

How did you first learn of our Clinic? Please check one:

- Attended Seminar Internet Sign outside building Book _____
- Born Clinic Web Site Radio Yellow Pages Friend or Family Member _____
- Newspaper Television Physician Other _____

Patient Name: _____ **Age:** _____ **Marital Status:** _____

Responsible Party: _____ **Relationship to patient:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work:** _____

Family Information, including patient:

First Name	M.I.	Last Name	Sex	DOB	Last 4 #s of SSN	Employer

In an emergency, please contact _____ **Phone:** _____

Please list allergies to any medications: _____

Surgeries: _____

Medications patient is taking on a regular basis: _____

Major medical problems: _____

BORN CLINIC FINANCIAL POLICY

Every effort is made to ensure that a visit to Born Clinic is a pleasant experience. We believe patients have a right to know and that the Clinic has an obligation to provide complete information about fee schedules and payment requirements. Unless you have Medicare or prior arrangements have been made for you, we appreciate total payment at the time services are rendered. Payment may be made by cash, check, MasterCard or Visa and you will be given an encounter form that you may send to your insurance company.

Born Clinic participates with Mediare but does not otherwise routinely file insurance claims. While we will cooperate to the fullest in providing you with accurate information so that you may bill your insurance company, you remain fully responsible for your account. If you have any questions regarding our financial policy, please feel free to speak with a receptionist or office manager.

Patient Signature: _____ **Date:** _____

Insurance Information. If you have multiple coverage, supply information from both carriers.

Name of <i>Primary</i> Insurance	Name of <i>Secondary</i> Insurance
Name of the Insured (name on ID card)	Name of the Insured (name on ID card)
Insured's date of birth:	Insured's date of birth:
Patient's relationship to the insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Patient's relationship to the insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
Insured ID#	Insured ID#
Group # or Company Name	Group # or Company Name
I authorize the release of my medical or other information necessary to process my claims(s):	
Patient or authorized person's signature: _____ Date: _____	
Is the patient's condition related to:	
<input type="checkbox"/> Employment <input type="checkbox"/> Auto Accident (if yes, state in which accident occurred: _____) <input type="checkbox"/> Other Accident	
Date of accident: ____/____/____ Date of first symptom of illness: ____/____/____ Claim No: _____	

Medicare Patients Only: We are participating physicians with Medicare. We will file all covered Medicare services for you and accept Medicare's allowable charge. We will bill you for any deductible and co-pays that you are responsible for. I, _____ (*patient name*), hereby acknowledge by this statement that I have been fully informed that some and perhaps all of the medical services provided at Born Clinic, P.C., on or after this date by Tammy L. Born, D.O., Dorothy A. Pedtke, D.O., Jeffrey P. Hendricks, M.D., Kayla R. Licari, P.A.-C., and their associates may be "non-covered" services and not considered reasonable and necessary under the Medicare program and/or other medical insurance. I realize that my insurance coverage, including Medicare, will not pay for such non-covered services, and I will be personally responsible for payments to the Born Clinic for such non-covered services.

I authorize payment of medical benefits be made on my behalf to Born Clinic, P.C., for any services furnished to me by Born Clinic. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____

Witness: _____ Date: _____