

INTERNAL MEDICINE ASSOCIATES OF GREENVILLE, P.A.

Name _____
(last) (first) (middle)

Address _____

_____ (city) (state) (zip code)
Social Security # _____ Sex: M F Date of Birth : _____

Marital Status: S M D W Emergency contact & number _____

Home phone # _____ Work phone # _____

Referring Physician _____ Phone # _____

Billing Information

Person responsible for paying bills: _____

Address if different than patient: _____

Primary Insurance _____

Claim mailing address _____

Subscriber name _____ Patient relationship to subscriber _____

Employer _____ Phone _____

Employer address _____

Subscriber Social Security # _____ Date of birth _____

Insurance ID # _____ Plan/Group # _____

Secondary Insurance _____

Claim mailing address _____

Subscriber name _____ Patient relationship to subscriber _____

Employer _____ Phone _____

Employer address _____

Subscriber Social Security # _____ Date of birth _____

Insurance ID # _____ Plan/Group # _____

It is the patient's responsibility to pay deductibles, co-insurance/co-pays on the day of service, and to pay any other balance not paid for by insurance. If we are filing your claim, we will allow forty-five days from the filing date for the carrier to process your claim and make payment. If an insurance payment is not received within this time frame, we will notify you to clear your account. Insurance filing is done as a courtesy to you and does not dismiss your responsibility to pay for services. Self-pay patients must pay for services the day on which they are rendered.

I understand that I am financially responsible for all charges incurred whether or not paid by an insurance carrier.

I hereby authorize said assignee to release all information necessary to secure payment. This assignment applies to all charges outstanding as the date of signature and will remain in effect for all current and future charges until revoked in writing. A photocopy of this assignment is to be considered as valid as the original. Should the account be referred to an attorney for collection the undersigned shall pay reasonable attorney's fees & collection expense.

Signature _____ Date _____

Parent (in minor) _____ Date _____