In order to serve you, we will need the following information. **(Please Print)**

All information will be strictly confidential.

Today's Date: _____ **Pharmacy:** _____

Patient's Name:	Sex: M F	Date of Birth / / Age: _____	Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐
Residence Address: City State Zip			
Mailing Address:	Patient's Phone: Home ( ) - Cell ( ) -		Patient's Social Security # - -
Name of Employer: Address:	Business Phone: ( ) -		Occupation:
Name of Spouse/Parent:	Employer		Business Phone: ( ) -
Primary Person To Contact In Case Of Emergency:	Relationship To Patient:		Phone: ( ) -
Are you a Migrant Farm Worker? Yes ☐ No ☐ Are you a Seasonal Farm Worker? Yes ☐ No ☐ Are you Homeless? Yes ☐ No ☐	What is your race/ethnicity? ☐ White ☐ Hispanic ☐ Other_____		What is your primary language?
Person Financially Responsible For This Account:	Responsible Party's Date of Birth / /		Responsible Party's Social Security # - -
Is it OK to leave a message on answering machine or with family member? Yes ☐ No ☐	For purposes of our **Patient Portal** we encourage an **Email address**:		
Primary Insurance Company: Address:			
Subscriber Name: ☐ Self ☐ Spouse (name) ☐ Parent (name)	Employer		Subscriber Date of Birth: / /
Policy #	Group #		
Secondary Insurance Company: Address:			
Subscriber Name: ☐ Self ☐ Spouse (name) ☐ Parent (name)	Employer		Subscriber Date of Birth / /
Policy #	Group #		

Received_____ Completed_____

I have been given a copy of Steck Medical Groups office policies and payment procedures:
Not limited to No show fees,Time of service payments and collections.

_____ _____
Patient Signature Date

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to STECK MEDICAL GROUP for any services provided to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

_____ _____
Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned, authorize payment of medical benefits to STECK MEDICAL GROUP for any services provided to me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____
Patient, Parent or Guardian Signature (if child is under 18 years old) Date

I agree to pay all charges for services provided to me and the following persons:

Patient Name (PLEASE PRINT): _____ **DOB:** _____

by STECK MEDICAL GROUP. I agree to pay all charges shown on Steck Medical Group statements in full, unless credit arrangements are agreed upon in advance of service in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of billing date. In the event collection efforts, including but not limited to legal action, should become necessary to collect any unpaid balance due for medical services rendered to me or the above named persons, I agree to pay the reasonable costs of collection, including but not limited to reasonable attorney's fees incurred in Lewis County. I agree that payments will not be delayed or withheld because of any insurance coverage or pendency of claims theron and all proceeds of insurance are assigned to STECK MEDICAL GROUP where applicable, but without STECK MEDICAL GROUP assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.) I understand that it is my responsibility and not that of STECK MEDICAL GROUP to obtain proper insurance or other payor authorization for medical examination or other treatment and that I am responsible for payment for all services rendered whether or not such services might have been covered by insurance or other source had proper authorization been obtained. I authorize STECK MEDICAL GROUP to bill my insurance carrier and payment will be sent directly to the provider. I give my specific authorization for these records to be released as necessary to complete billing to my insurance company or account holder. All accounts are due and payable in full within thrity (30) days from the statement date. In the event that the account is not paid in full within thirty (30) days of the statement date, a finance charge of one percent (1%) per month, which amounts to twelve (12%) per year, will be added on the outstanding balance(s) over sixty (60) days old.

I hereby consent to all medical treatment as ordered by the attending physician or health care staff of STECK MEDICAL GROUP.

_____ Date: _____
SIGNATURE OF RESPONSIBLE PARTY / GUARDIAN

_____
PRINT NAME OF RESPONSIBLE PARTY / GUARDIAN

☐ Self ☐ Parent ☐ Guardian ☐ Other (specify) _____