Carol A Fischer M.D.
1331 Prairie Avenue #2 Cheyenne, WY 82009 307-778-3121
New_____ Update_____

PATIENT INFORMATION

Patient's Legal Name_____Today's Date_____

Address_____Zip Code_____ Home Phone_____
(Leave Message? Y / N
Sex_____Age_____ D.O.B_____ SS#_____ _____ _____Cell Phone_____
(Leave Message?) Y / N
Marital Status_____ Employment Status_____ Work Phone_____
Email Address_____ (Leave Message?) Y / N
Employer's Name _____Address_____
Race_____ Language most spoken_____ Nationality_____
( ) Parent's or Spouse's Name_____
( ) Parent's or Spouse's Employer &Address_____Phone_____
Patient's Emergency Contact_____ Phone #_____Relation to Patient_____
Patient's Primary Care Physician or Referring Doctor's Name_____

DO YOU HAVE INSURANCE? Yes___No___

PRIMARY INSURANCE
Name _____ID#_____Phone#_____
Address_____Insurance Card Holder's Name_____
SS# of Card Holder_____ _____ _____D.O.B. _____Relation to Patient_____

SECONDARY INSURANCE
Name_____ ID#_____Phone_____
Address_____Insurance Card Holder's Name_____
SS# of Card Holder _____ _____ _____ D.O.B. _____Relation to Patient_____

WORKER'S COMPENSATION:
Claim #_____Injured Body Part_____Date of Injury_____
Employer's Name & Phone # (at time of injury)_____
Are you working now? Yes____ No____ Have you filed a claim with Employer?_____

IS LEGAL ACTION OR LITIGATION PENDING FOR THIS INJURY? Yes___ No___
If so due to the constraints, (Carol A. Fischer's Office) may not be able to become involved in your care.

PAYMENT IS EXPECTED AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS ARE MADE.WE ACCEPT CASH/ CHECKS/VISA/MASTERCARD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been offered a Notice of Privacy Practices of Carol A. Fischer M.D. I understand that my Protected Health Information (PHI) may be used and disclosed for the purposes of TREATMENT, PAYMENT, and HEALTHCARE OPERATION of the practice.

_____ _____

DATE PATIENT'S SIGNATURE

_____ _____

SIGNATURE OF PATIENT REPRESENTATIVE **RELATIONSHIP**

(Required if the patient is a minor or an adult who is unable to sign)

WRITTEN AUTHORIZATION FOR RELEASE OF PHI

I hereby authorize Carol A. Fischer M.D. to discuss my Protected Health Information (PHI) with the following person. Should I wish to revoke this authorization I understand I must do so in **WRITING.**

NAME_____ PHONE_____

RELATIONSHIP_____

_____ _____

DATE PATIENT SIGNATURE

_____ _____

SIGNATURE OF PATIENT REPRESENTATIVE RELATIONSHIP

(Required if the patient is a minor or an adult who is unable to sign)

CONSENT TO ASSIGNMENT OF BENEFITS AND PROMISE TO PAY

Promise to Pay:

I understand and agree that I am responsible to pay for all services provided to me by Carol A. Fischer M.D. and its staff and other physician assistants that may be utilized during treatment and surgery. If I fail to pay for the services when they are rendered or on a signed agreed payment schedule, I will be responsible for all the costs of collection, including but not limited to, court cost and fees, attorney fees, and collection agency fees of the unpaid balance assigned for collection.

Benefits to Physician:

I hereby assign all of my rights to Insurance benefits and instruct my insurance company to make payments directly to Carol A. Fischer M.D. for the benefits provided.

_____ _____

Date Patient Signature

_____ _____

Signature of the patient RepresentativeRelationship

(Required if the patient is a minor or an adult unable to sign)

GENERAL INFORMATION

When you arrive for your appointment please give your **current** Insurance cards and Driver's license to the receptionist to scan in our system. We accept assignment for insurance benefits and are participating providers for many insurances. Your co pay's, deductibles, percentages, etc are to be paid at the time of your visit or your insurance will not be billed. Please remember your insurance policy is a contract between you and them. You are required to pay your remaining balance in full after your insurances have paid. If your claim is not paid within 90 days your balance owed will be turned over to our collection service.

Carol A Fischer M.D. office is committed to providing the best treatment possible for our patient's at rates that are usual and customary for our area. You are responsible for payment in full regardless of the interpretation of what is usual and customary by a given insurance company.

The adult accompanying a minor (parent/guardian/etc) is responsible for full payment at the time of service. **Anyone under the age of 18 is considered a minor and must have a parent/guardian present and their consent before treatment can be given.**

We do call and confirm to remind patients of their visits the day prior to the appointments. If you wish us not to call, please notify the receptionist after completing this form. If you have any concerns and complaints about our employee's we ask that you put it in writing and submit it to the physician you are seeing.

Thank you for understanding our policies. Please let us know if you have any questions or concerns.