Coastal Carolina Internal Medicine, PA
PATIENT INFORMATION

Acct# _____ (office use only)

Pt Name: _____ Hm Phne # ( ) _____
Last First Middle
Cell: ( ) _____daytime # ( ) _____

Home Address: _____
Street City State Zip Code

Social Security # ____/ ____/ ____ Date of Birth ____/ ____/ ____ Current Age ____ Sex: M ____ F ____

Ethnic Group: Hispanic or Latino ___ Race: Hispanic: ___

Non-Hispanic or Latino ___ Decline to State: ___ Non-Hispanic: ___

Patient Employer (current): _____

Address: _____ Work#: ( ) _____

Billing address: ( ) if the same as home address if not indicate here: _____

Spouses Name:_____ Date of Birth: ____/ ____/ ____

Spouses Employer (Name and Address) _____

EMERGENCY CONTACT (local relative or friend): _____ Ph#:_____

Referred to this office by: _____
(please indicate if you want us to contact that person to thank them of this referral ___ Yes __ NO

INSURANCE: *** Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is NOT a substitute for payment. Some companies pays an allowance for certain procedures and other pay a percentage of the charge. Secondary insurance will be filed as a courtesy. We will no longer file any Tertiary insurance. It is your responsibility to pay the deductible, co-insurance, and co-pay at the time of the visit. Co-payment and deductible will be collected upon check-in.

Please list down the insurance you want us to file your medical claims to: PRIMARY _____ SECONDARY _____ ANY UNPAID balance that is 90 days and over will be forwarded to the collection agency, SCA. An agency collection fee of 33% will be added to the owed balance and you may be discharged from the practice.

RESPONSIBLE PARTY (GUARANTOR) The patient will be ultimately responsible for any balance owed to CCIM, PA unless otherwise indicated below.

_____ (___) _____
Last Name First Middle Phone#

SIGNATURE of Responsible Party _____
PLEASE READ AND SIGN:
I directly assign all medical/surgical benefits to COASTAL CAROLINA INTERAL MEDICINE, PA (Dr. Jose I. Ros). I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor and his staff to release all information necessary to ensure payment of benefits. I further agree that photocopy of this agreement shall be valid as the original

RETURN CHECK FEE: $35
NO SHOW AND LATE CANCELLATION FEE $40 (at least 24 hours notice is required for cancellations)

PATIENT SIGNATURE: _____ DATE: _____