

Acct No: _____ Reg. By: _____ Entered Date: _____ Office Site: _____

Please complete this form in order to ensure proper billing of your services. **Please Print.** Today's Date: _____

Patient Name: _____ Last Name First Name MI	Social Security Number: _____
Other Name: _____	Date of Birth: _____
SEX: <input type="checkbox"/> M <input type="checkbox"/> F	Race: (Response is not mandatory. Data is used for statistical reporting.)
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed	<input type="checkbox"/> African American <input type="checkbox"/> Asian/Oriental <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic
<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Other	<input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Addr1: _____	Home Phone: (____) _____
Addr2: _____	Daytime Phone: (____) _____
City,St,ZIP: _____	Cell Phone: (____) _____
Employer: _____	Emp Status: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Homemaker
Addr1: _____	<input type="checkbox"/> Other _____ <input type="checkbox"/> Student <input type="checkbox"/> Active Military <input type="checkbox"/> Self-Employed
Addr2: _____	Work Phone: (____) _____
City,St,ZIP: _____	

Please complete if guarantor is other than self. (The guarantor is the person financially responsible for this patient's bill.)

Guarantor: _____	Patient's Relationship to Guarantor: _____
Addr1: _____	Social Security Number: _____
Addr2: _____	Date of Birth: _____
City,St,ZIP: _____	Sex: _____
Employer: _____	Home Phone: (____) _____
Addr1: _____	Work Phone: (____) _____
Addr2: _____	
City,St,ZIP: _____	

Emerg Cont: _____	Patient's Relationship to Emerg Cont: _____
Addr1: _____	Home Phone: (____) _____
Addr2: _____	Work Phone: (____) _____
City,St,ZIP: _____	Cell Phone: (____) _____

How did you hear of our practice? Billboard Brochure Health Fair Health Plan Internet JeFF NOW Mass Mailing
 Newspaper/Mag. Ongoing Care Other Patient Phone Bk Phys. Off./ER Relative Radio TV Word of Mouth

Insurance Information

A separate form is required for Worker's Compensation, Automobile Liability, or Legal services.

PRIMARY CARRIER: _____

Address: _____	Telephone #: (____) _____
Group/Plan #: _____	ID/Cert #: _____
Subscriber's Name: _____	Subscriber's DOB: _____
Relationship to Patient: _____	Effective Date: _____

SECONDARY CARRIER: _____

Address: _____	Telephone #: (____) _____
Group/Plan #: _____	ID/Cert #: _____
Subscriber's Name: _____	Subscriber's DOB: _____
Relationship to Patient: _____	Effective Date: _____

Primary Care Physician/Referring Physician

PCP: _____	Refer. Phys. (if different): _____
Addr: _____	Addr: _____
City,St,ZIP: _____	City,St,ZIP: _____
Telephone #: _____	Telephone #: _____

ASSIGNMENT OF BENEFITS

Medicare I request that payment of authorized Medicare benefits be made either to me or on my behalf to Main Line HealthCare and/or to the individual Attending Physician, for any services furnished to me by that Physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or the party who accepts assignment.

In order to comply with Medicare regulations, please answer the following questions:

Are you or your spouse employed?	<input type="checkbox"/> Y <input type="checkbox"/> N	Has treatment been authorized by the V.A.?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you or your spouse have other insurance?	<input type="checkbox"/> Y <input type="checkbox"/> N	Are you covered under the Black Lung Program?	<input type="checkbox"/> Y <input type="checkbox"/> N
Are you disabled or have end stage renal disease?	<input type="checkbox"/> Y <input type="checkbox"/> N	Is there Medigap coverage secondary to Medicare?	<input type="checkbox"/> Y <input type="checkbox"/> N
Is illness/injury the result of an auto accident?	<input type="checkbox"/> Y <input type="checkbox"/> N	Is there insurance coverage primary to Medicare?	<input type="checkbox"/> Y <input type="checkbox"/> N
Did illness/injury occur at work?	<input type="checkbox"/> Y <input type="checkbox"/> N	Is there employer supplemental coverage secondary to Medicare?.....	<input type="checkbox"/> Y <input type="checkbox"/> N

Medigap (Medicare Secondary Insurance) I request that payment of authorized Medigap benefits be made either to me or on my behalf to Main Line HealthCare for any services furnished to me by that physician. I authorize any holder of Medicare information about me to release to _____ (Name of Medigap Coverage) any information needed to determine these benefits payable for related services.

Pennsylvania Medical Assistance I understand that payment for service(s) or items received will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State laws.

Commercial **ASSIGNMENT OF INSURANCE BENEFITS** - I hereby authorize payment directly to Main Line HealthCare for medical benefits including any Major Medical benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to the physicians. In making this assignment, I understand and agree that I am financially responsible to the above party for charges not paid under this insurance policy. I permit a copy of this authorization to be used in place of the original.

General **RELEASE OF INFORMATION** – Main Line HealthCare may disclose any or all parts of my clinical records to my insurance company or companies, or, in the case of Workers Compensation claims, to my past or present employer(s), for purposes of satisfying charges billed by Main Line HealthCare and/or its physicians. This authorization does not cover requests from other parties seeking information regarding my account.

GUARANTEE OF ACCOUNT – Main Line HealthCare

For and in consideration of services rendered by Main Line HealthCare to the below named patient, the undersigned (jointly and severally if more than one) guarantees payment of all charges incurred for said patient in accordance with the policy of payment of such bills.

THE UNDERSIGNED CERTIFIES THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS.

Patient Signature Date

Patient's Agent Representative and Guarantor Signature Date