BANDER FAMILY MEDICAL

Dr. Steven G. Bander, D.O. Carol Kick, RN, MS, FNPC

New Patient Form

Patient Name: Last:_______________________First:____________________

DOB: ____-____-______ Sex: Male / Female SSN:_____-_______-_______

Marital Status : Single / Married / Divorce / Widow-Widower

Home Address:____________________________________ City: ____________

State: ______________ Zip Code: ________________.

Contact Info/Numbers: Home:______________________ Cell:________________

Work:______________________ Email 1:_________________________

Email 2:___________________________

Would you like labs/reports emailed to you? Yes / No
(Please note if you do not want information emailed to you, we do not need your email address on file)

How would you like to be contacted for results (Labs, consults, other test results)Check all that apply, if none, make sure contact info is correct: ( ) Email ( ) Home Number ( ) Cell ( ) Family Member(s) on HIPAA ( ) None (we will just send a card in the mail)
Have you filled out a HIPAA form in the past year? Yes / No
If no, please update your HIPAA, this is required yearly.

Emergency Contact(s): ____________________________________
Relation:__________________________ Number: __________________
Contact 2: ____
Relation:__________________________Number:__________________

Bander Family Medical is required by CMS to report on the following items. Accounting on such items does not reflect the views of the practice. Please use the "refuse to report" option if you care to not participate.

Race: ( ) American Indian or Alaska Native ( ) Asian ( ) African American ( ) Native Hawaiian or Other ( ) White ( ) Refuse to report (Check all that apply)

Ethnicity: ( ) Latino or Hispanic ( ) Non-Latino or Non-Hispanic ( ) Refuse to report

Language: ( ) English ( ) French ( ) German ( ) Japanese ( ) Mandarin ( ) Russian ( ) Spanish ( ) Other: ________________ ( ) Refuse to Report (Check all that apply)

Case Information

Are you self pay: Yes / No (please note if you are self pay, just fill out the guarantor info if different then patient)

Primary Insurance Company: ______________________________

Address: ______________________________ City:______________

State:__________ Zip Code:______________

Number: ______________________________ Effective Date:______________

Policy/Subscriber ID: ______________________ Group #:______________

Copay: $________ Coinsurance: ________% Yearly Deductible: $__________

Secondary Insurance Company:______________________________

Address: ______________________________ City:______________

State:__________ Zip Code:______________

Number: ______________________________

Policy/Subscriber ID: ______________________ Group #:______________

Does your secondary cover all expenses remaining from your primary: Yes / No

Copay: $________ Coinsurance: ________% Yearly Deductible: $__________

Policy Holder/Guarantor Info (Primary / Secondary) If different from patient info above

Name: Last______________________________ First______________________

DOB: _____-_______-________ Sex: Male / Female

SSN:______________________ Relation to Patient:______________

Home Address:______________________________ City: ______________

State: ____________ Zip Code: ______________

Contact Info/Numbers: Home:__________________ Cell:______________

Work:__________________ Email 1:______________________

By signing you agree all the above information is correct and current. Insurance coverage is a contract between you and the insurance company. There are some treatments that are not covered by your insurance. We cannot be responsible to know what your policy covers. All non-covered expenses will be your responsibility. If you are self pay, payment is required at time of service. You must bring a valid ID and Insurance Card with you every visit.

Patient/Guarantor Signature: ______________________ Date:______________

Relation to Patient if not self: ______________

Consents

I authorize Bander Family Medical to initiate and maintain medical/surgical treatment of myself/my child in an emergency or life threatening situation until proper notification can be given and consent obtained. I authorize release of medical or other information acquired during the course of examination and treatment to insurance carriers. I hereby request payment benefits to Bander Family Medical. I understand I am responsible for any amount not covered by insurance.

Signature: ______________________________ **Date:** ______________

Policies

In order to make coming to the doctor's office as pleasurable and convenient as possible, we have established the following policies:

- We accept cash, check, Master Card, and Visa.
- We do not accept Auto insurance. This is considered a third party payer and we are unable to accept this.
- If you are a member of a PPO or HMO you must pay your co-pay at the time of service. We must have a copy of your insurance card on file. ***It is your responsibility to be sure we are covered by your plan*.**
- We do accept assignment on Medicare and will file secondary insurance for Medicare patients provided we have been given all of the necessary information.
- If this is your first visit to our office and you are not a member of a PPO or Medicare, we do require payment at the time of service. We will be happy to file your insurance.
- You are responsible for full payment of all fees by any child that you bring in for treatment. We will not mediate between parents.
- Some laboratory procedures will be billed by the lab to your insurance carrier.
- Insurance coverage is a contract between you and the insurance company. There are some treatments that are not covered by your insurance. We will endeavor to inform you if we know a service is not covered by your insurance company, but we cannot be responsible to know what your policy covers. All non-covered expenses will be your responsibility.

YOUR COOPERATION WITH THE ABOVE POLICIES WILL HELP US SERVE YOU AND YOUR CHILDREN BETTER. THANK YOU!

Signature: ______________________________ **Date:** ______________