PATIENT AND GUARANTOR INFORMATION FORM **MIDLAND/BAY ALLERGY CLINIC**

***PLEASE PRINT / ALL INFORMATION MUST BE COMPLETELY FILLED OUT BEFORE ANY SERVICE WILL BE RENDERED**

PATIENT NAME:_____ MALE___ FEMALE___ **BIRTHDATE**:_____/_____/_____
(FIRST) (M.I.) (LAST)

MARITAL STATUS: ☐ S ☐ M ☐ D ☐ W **SOCIAL SECURITY #**:_____

ADDRESS:_____CITY:_____ZIP:_____

HOME PHONE#:_____**CELL PHONE#:** _____**WK#**:_____

PT. EMPLOYER:_____EMPLOYER ADDRESS:_____

EMERGENCY CONTACT:_____RELATIONSHIP:_____PHONE#:_____

***CHIEF COMPLAINT OR REASON FOR VISIT?**_____

FAMILY DOCTOR:_____**PH#**_____**LOCATION:**_____

FINANCIAL RESPONSIBILITY - MUST BE FILLED IN COMPLETELY BY PATIENT OR THE PARENT OF MINOR

PLEASE NOTE: **GUARANTOR INFORMATION IS ABOUT THE PERSON SIGNING ALL FORMS**! WE ARE PROVIDING A SERVICE TO THE PATIENT AND FINANCIAL RESPONSIBILITY WILL BE THE PERSON BRINGING THE CHILD/CHILDREN IN FOR TREATMENT**. Receipts available upon request.**

GUARANTOR NAME:_____ss#_____DOB:_____

RELATIONSHIP TO PATIENT:_____PHONE:_____CELL:_____

Address:_____city:_____zip:_____

EMPLOYER:_____**ADDRESS:**_____**PH#**_____

INSURANCE COVERAGE FOR PATIENT

PRIMARY INSURANCE_____

SUBSCRIBER:_____

EMPLOYER:_____

CONTRACT#_____

DOB:_____**GROUP#**_____

EFFECTIVE DATE_____ **HMO?**_____

SECOND INSURANCE_____

SUBSCRIBER:_____

EMPLOYER:_____

CONTRACT#_____

DOB:_____**GROUP#**_____

EFFECTIVE DATE_____ **HMO?**_____

I CONSENT TO THE TREATMENT PLAN NECESSARY FOR THE CARE OF THE ABOVE NAMED PATIENT. I AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS TO THE REFERRING AND FAMILY PHYSICIANS, AND TO THE INSURANCE COMPANIES LISTED ON THIS FORM. I WILL ALSO ALLOW FAX TRANSMITTAL OF MY MEDICAL RECORDS IF NECESSARY.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL COPAYS, REJECTIONS, DEDUCTIBLES, AND NON-COVERED SERVICES. I AGREE TO PAY ALL REASON FEES ASSESSED IF ACCOUNT IS REFERRED TO COLLECTION EFFORTS AND ATTORNEYS IN THE EVENT OF DEFAULT ON PAYMENT FOR THE ABOVE PATIENT. I FURTHER AUTHORIZE AND REQUEST THAT INSURANCE PAYMENTS BE MADE DIRECTLY TO RICHARD J. HORBAL, M.D., P.C. OR JONATHAN M. HORBAL, D.O., P.L.C. SHOULD THEY ELECT TO RECEIVE SUCH PAYMENT.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR TREATMENT, FINANCIAL RESPONSIBILITY, RELEASE OF INFORMATION AND INSURANCE AUTHORIZATION. THIS IS A ONE TIME AUTHORIZATION ON FILE AND VALID FOR ALL FUTURE SERVICES.

GUARANTOR SIGNATURE: **X**_____DATE:_____

OFFICE PERSONNEL ONLY: FORM REVISION 01-2016

PATIENT NAME:_____ **ACCT#**_____ **EMP. INITIALS:**_____

SUBMIT FORM