



PATIENT INFORMATION

FULL NAME _____ TODAY DATE _____

DATE OF BIRTH _____ SEX: MALE FEMALE _____

IF CHILD: PARENT NAME _____ PHONE _____

PARENT NAME _____ PHONE _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

EMAIL ADDRESS _____ Initial if OK to text _____ email _____

PREFERRED LANGUAGE _____ INTERPRETER NEEDED? YES NO

REFERRING PHYSICIAN _____ City _____

PRIMARY CARE PHYSICIAN _____ City _____

PHARMACY _____ ADDRESS: _____

PRIMARY INSURANCE INFORMATION / RESPONSIBLE PARTY

INSURANCE COMPANY _____

ID # _____ GROUP # _____

POLICY HOLDER NAME _____ DOB: _____

RELATIONSHIP _____ SSN _____ PHONE _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

SECONDARY INSURANCE COMPANY: _____

EMERGENCY CONTACT _____ PHONE _____

PERMISSION TO DISCLOSE MEDICAL INFORMATION AND SEEK TREATMENT

I, (guardian name) _____ authorize the following people to seek, obtain and consent to medical care and treatment for _____ (child name).

NAME: _____ PHONE _____

NAME: _____ PHONE _____

SIGNATURE _____ DATE _____

PATIENT NAME _____ DOB _____

INSURANCE PAYMENT AUTHORIZATION

_____ I authorize SPECS LLC and its representatives to file my primary and secondary insurance and receive payments for services rendered. **I understand that I am responsible for the deductible, coinsurance, and non-covered services. Coinsurance and deductible amounts are based upon charge determination of my insurance carrier. I understand that I am responsible for any balance that is not paid or covered by my insurance.**

PATIENT PAYMENT AUTHORIZATION

_____ I understand that if I do not have insurance or that SPECS LLC is not a provider with my insurance, then I will be responsible for any balance that is not covered.

MEDICARE LIFETIME AUTHORIZATION

_____ I request the payment of authorized Medicare benefits be made on my behalf to SPECS, LLC for services furnished to me. I authorize any holder of my medical information to release to HCFA and its agents any information needed to determine benefits or benefits payable for related services.

I understand that I am responsible for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon charge determination of the Medicare carrier.

I RECEIVED THE NOTICE OF PRIVACY PRACTICES FOR *SPECS, LLC* .

I RECEIVED AND AGREE TO THE *SPECS, LLC* OFFICE AND FINANCIAL POLICY.

PATIENT/GUARDIAN SIGNATURE _____

PRINT NAME _____ DATE _____