Anthropos Health & Counseling Center PLLC

PLEASE PROVIDE THE RECEPTIONIST YOUR INSURANCE CARD(S) AND PHOTO ID. IT WILL BE COPIED AND RETURNED TO YOU. ● *cash pay*

Last Name:				☐ MALE ☐ FEMALE
First Name:	MI:	SSN:		Home Phone:
Address:	Date of Birth:	Age:		Cell Phone:
City:	State:	ZIP + 4:	Date of Injury:	Work Phone:
Employer:		Occupation:		
Email Address:		Referring / PCP:		
Name & Relationship to insured:	Insured DOB:	Insured SS#:	Insured Employer:	

If this is an Injury claim, does an Attorney represent you? ☐ YES ☐ NO
Name and phone number of Attorney:

Restrictions:
May we EMAIL or TEXT your cell phone with information or questions? ☐ YES ☐ NO
May we call and leave message(s) with anyone who answers your phone? ☐ YES ☐ NO
May we call and leave message(s) on your home phone? ☐ YES ☐ NO

Emergency Contact Person Last Name:	First Name:	Phone:

Please indicate the name(s), DOB(s), and relationship of person(s) you authorize to have access to your medical information.

☐ **PROVIDED A COPY OF INSURANCE CARD?** ☐ **PROVIDED A COPY OF PHOTO ID?**

Would you like your credit/debit card to remain on file and used for outstanding balances?

Signature _____ *Date* _____ *Name on Card* _____

ID# _____ *Exp Date* _____ *3 digit Security* _____

ACKNOWLEDGEMENT OF *Notice of Privacy* PRACTICES

I have been informed - either in writing or verbally - of the "Notice of Privacy" practices *(HIPAA regulation)*

Signature: _____ Date: _____

NON MEDICARE LIFETIME AUTHORIZATION, Assignment and Release: I hereby authorize payment directly to my provider for all insurance benefits otherwise payable to me for medical services rendered. I understand that I am financially responsible for all charges, whether or not allowed or paid by my insurance, and for all services rendered on behalf of my dependents. I also understand that it is my responsibility to know when my maximum insurance benefits have been met and I agree to pay for services at full fee thereafter. I authorize my provider to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I AM AWARE AND AGREE TO A "NO SHOW FEE" OF $50.00 IF I FAIL TO CALL AND CANCEL MY APPOINTMENT WITHIN 24 HOURS OF MY SCHEDULED APPOINTMENT TIME. *I have read, understand, and agree to the above.*

_____ Date

_____ Signature of Guarantor

Office Use only:

SCANNED ☐ This form ☐ Copies of the insurance cards – front and back ☐ Photo ID

REV: 02012019