Progressive Family Care

BELMAR FAMILY MEDICINE

for a Healthy Future

Name of Patient _____
First Middle Last

Street Address _____ **Apt.** _____

City _____ **State** _____ **Zip** _____

Home Phone # _____ **Cell Phone #** _____

Date of Birth _____ **Sex** _____ **Marital Status** _____

Social Security # _____ **Drivers License #** _____

Education Level Grade School High School College Advanced Degree **Religion** _____

Employer Name _____

Work Telephone Number _____ **Occupation** _____

SUBSCRIBER'S INFORMATION – Who Carries the Insurance? ☐ - **Same as Above**

Name _____

Address _____

Home Phone # _____ **Cell Phone #** _____

Date of Birth _____ **Social Security #** _____

Employer Name _____

PRIMARY HEALTH INSURANCE

Insurance Name _____
Group Name / # _____
Policy Number _____
Policyholder Name _____
Co-payment _____
Effective Date _____

SECONDARY HEALTH INSURANCE

_____
_____
_____
_____
_____
_____

EMERGENCY CONTACT

Name _____ Relationship _____
Address _____ Telephone # _____

I hereby authorize payment directly to Belmar Family Medicine, P.C. and authorize the release of any information necessary to process insurance claims. I voluntarily consent to examination and treatment for myself and / or dependants.

I will be responsible for the full amount of the charges except those under Belmar Family Medicine, P.C.'s contractual arrangements with insurance payers. I will keep my account in good standing and will pay my account in full within 90 days from the time of service. Should the account be turned over to collections, I will pay all costs of colleciton including, but not limited to, agency fees, attorney fees, and court costs.

I understand that a monthly finance charge of 1.5% (18% annually) will be assessed on any unpaid balance.

Signature of Patient/ Responsible Person _____ **Date** _____

WE RESERVE THE RIGHT TO CHARGE $50.00 FOR MISSED APPOINTMENTS. PLEASE GIVE 24 HOURS CANCELLLATION NOTICE