PATIENT INFORMATION

James L. Autin, M.D., P.A.
Kenneth S. Weiss, M.D., P.A., F.A.C.S.

Date _____

PLEASE PRINT CLEARLY

Patient Name _____ Age_____
Address _____ City _____
State _____ Zip _____ Home Phone_____ Sex_____
Date of Birth _____ Marital Status_____ Social Sec. # _____
Referring Dr. _____ Employer_____
Daytime Phone _____ Occupation _____
Cell Phone _____ Work Phone _____
* Email Address _____ Race _____
Preferred Language _____ Ethnicity _____
Nearest Relative Not Living With You _____ Phone _____

PERMANENT ADDRESS, IF NOT SAME AS ABOVE:

Out of State Address _____
Out of State Phone _____

RESPONSIBLE FOR PATIENT (MUST BE COMPLETED IF PATIENT IS UNDER 18)

Legal Guardian _____ Relationship _____
Social Sec. # _____ Phone _____
Employer _____ _____ Phone _____

INSURANCE INFORMATION:

Insurance Co. _____I.D. No. _____
Name of Insured As It Appears On Card _____DOB of Insured_____
Group/Code No. _____ Insurance Co. Address_____
City _____ State_____ Zip _____ Phone _____

Secondary Insurance

Insurance Co. _____I.D. No. _____
Name of Insured _____DOB of Insured_____
Group/Code No. _____ Insurance Co. Address_____
City _____ State_____ Zip _____ Phone _____

PAYMENT INFORMATION

Work Related _____ Accident _____ Other _____

I Will Be Paying Today By: ☐ Cash ☐ Check ☐ Credit Card

For Convenience, Please Keep My Credit Card Info on File

Name (as it appears on card) _____
Zip Code_____
Card No. _____
Card Type: VISA MasterCard Exp. Date _____ / _____ / _____
Signature: _____

THIS FORM IS NOT COMPLETED UNTIL THE REVERSE SIDE HAS BEEN READ AND SIGNED.

MEDICAL AUTHORIZATION:

I hereby authorize medical treatment of the above named patient by James L. Autin, M.D., P.A. and/or Kenneth S. Weiss, M.D., P.A.

I hereby authorize release of any medical information from any previous doctors or hospitals or other medical facility to James L. Autin, M.D., P.A. and/or Kenneth S. Weiss, M.D., P.A.

I hereby authorize James L. Autin, M.D., P.A. and/or Kenneth S. Weiss, M.D., P.A. to release any medical information acquired in the course of my treatment to authorized parties requesting such information.

I understand that insurance is considered a method of reimbursing the patient for fees paid to doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance.

IN ORDER TO CONTROL YOUR COST OF BILLING, WE REQUEST THAT YOUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

An administrative fee of up to 25% of the balance will be charged if my account is turned over to a collection agency for non-payment.

If this account is assigned to an attorney for collection and/or suit, I agree to pay reasonable attorney's fees and cost of collection.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record.

I hereby assign all medical and/or all surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to James L. Autin, M.D., P.A. and/or Kenneth S. Weiss, M.D., P.A.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered a valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

I authorize James L. Autin, M.D., P.A. and/or Kenneth S. Weiss, M.D., P.A. to initiate a complaint to the state Insurance Commissioner for any reason on my behalf.

I have reviewed the privacy notice provided by Dr. Autin's and/or Dr. Weiss' office.
(*A copy provided upon request*) _____ Initial.

I authorize permission for electronic transmittal of prescriptions and medication history update when available. (E-scribing) (Download of past medication history)_____ Initial.

As a courtesy to you we generally make a reminder call before all appointments. In the event we are unable to contact you personally we will leave a message stating appointment time and date.

Yes _____ No _____ Which Phone # _____

I give permission to Dr. James L. Autin M.D., P.A. and/or Kenneth S. Weiss, M.D., P.A. and staff to speak with_____ on my behalf regarding my medical history and treatment.

SIGNED_____Date_____

A 25.00 dollar no show fee will be charged if 24 hour cancellation notice is not given.
We charge $10.00 per form to be filled out and require 48 hours for completion.
(Example: Insurance Forms, Leave of Absence, Disability Forms)