CONVENIENT CARE
FAMILY MEDICINE

Billing and Insurance information

*Due to the amount of information required for our office to process/submit a claim, please complete **ALL PORTIONS** of this form. It is also crucial that you supply the physician and staff with your most current and up-to-date insurance information. You will be asked to update this information a minimum of annually. Your patience and attention to detail are much appreciated.*

Name Mr/Mrs Miss/Ms. Dr. Last First MI

Address Apt# City State Zip code Phone # Cell # (If you want to use as secondary contact)

SSN # Date of birth Age Sex E-mail address

Employer: Employer Address City State Work/ Bus Phone

Spouse/or Guardian's Name Work Phone

Emergency Contact Name Address City State Phone

Referred to this office by:

Name of last Physician seen:

***MINOR OR DEPENDENT PATIENT ON PARENT/GUARDIAN'S INSURANCE** - Please fill in shaded area below

*Mother's name Phone(If different from above) Father's name Phone (If different from above) Work phone (If different from above)

Primary Insured Card Holder or Responsible party – If other than above

**Must* have name, date of birth and SS# to file insurance

*Name *Date of birth *Social Security #

Address City State Phone # Relationship to patient (Parent, Guardian, Spouse)

Employer Company Address City State Bus phone #

Method of payment: __Cash __Check __Credit card __Insurance

Name of Insurance Company_____

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

Please read & sign the following:

I directly assign all medical / surgical benefits to: KTD, PLLC, D.B.A. *Convenient Care Clinic, Kelly S. Doggett,MD*. **I understand that I am financially responsible for all charges** whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

SIGN HERE_____**DATE**_____