BILLING INFORMATION (EMAIL REQUIRED TO RECEIVE OFFICE INFORMATION)

PATIENT INFORMATION **DATE:** ___________________

DRIVER'S LICENSE: _______________________________ **STATE:**__________

Please Write Clearly & Complete all Sections

NAME:____
Last First Middle Initial

HOME ADDRESS:____

CITY:__________________________________ STATE:________ ZIP:_____________

SOCIAL SECURITY #:_________________________ SEX: M ____ F ____ AGE:_________

BIRTHDATE:_________________ MRD_____SGL_____DIV_____SEP_____WID_____

ETHNICITY: Hispanic ___ Non-Hispanic ___ Other ___

RACE: White ___ Black ___ Hispanic ___ Asian ___

Other ___ *Race & Ethnicity required by Medicare/Insurances*

Preferred Language: English ___ Spanish ___ Other __

HOME PHONE __________________________________

CELL PHONE __________________________________

WORK PHONE __________________________________

EMAIL:_______________________________________

EMPLOYER:____________________________________

PROFESSION:___________________________________

WORK ADDRESS: _______________________________

CITY:___________________________ZIP___________

SPOUSE (IF ANY) or FATHER (IF UNDER 18) INFORMATION

NAME:____

HOME ADDRESS:____

CITY:________________________________ STATE:________ ZIP:_____________

SOCIAL SECURITY #:_________________________ SEX: M ____ F ____ AGE:________

BIRTHDATE:___________________ MRD____ SGL___ DIV____ SEP____ WID____

HOME PHONE __________________________________

CELL PHONE __________________________________

WORK PHONE __________________________________

EMAIL:_______________________________________

EMPLOYER:____________________________________

PROFESSION:___________________________________

WORK ADDRESS: _______________________________

CITY:___________________________ZIP___________

MOTHER (IF UNDER 18) OR GUARANTOR INFORMATION

NAME:____

HOME ADDRESS:____

CITY:________________________________ STATE:________ ZIP:_____________

SOCIAL SECURITY #:_________________________ SEX: M ____ F ____ AGE:________

BIRTHDATE:___________________ MRD____SGL____DIV____SEP____WID____

HOME PHONE __________________________________

CELL PHONE __________________________________

WORK PHONE __________________________________

EMAIL:_______________________________________

EMPLOYER:____________________________________

PROFESSION:___________________________________

WORK ADDRESS: _______________________________

CITY:___________________________ZIP___________

LIST ALL CHILDREN

NAME	SEX	DOB	NAME	SEX	DOB
____________________	M ___ F ___	__________	____________________	M ___ F ___	__________
____________________	M ___ F ___	__________	____________________	M ___ F ___	__________
____________________	M ___ F ___	__________	____________________	M ___ F ___	__________
____________________	M ___ F ___	__________	____________________	M ___ F ___	__________

EMERGENCY CONTACTS
NOT LIVING AT HOME

NAME:___________________________

PHONE __________________________

NAME:___________________________

PHONE __________________________

HOW ARE YOU PAYING FOR SERVICES RENDERED TODAY & IN FUTURE?

CASH______ CHECK_______ CREDIT CARD________ PPO ______ HMO________ CARE CREDIT__________

UPDATE INSURANCE INFORMATION / ADDRESS / PHONE # AT EACH VISIT

I will Update any Changes to my Insurance / Medicare / HMO Information / Address & Phone at Each Visit. I will be Responsible for All Fees and Charges Incurred by me or my dependents. *RESPONSIBLE PARTY INITIALS:* _____________

***How did you find us?* ____**

PRESENT YOUR NEW INSURANCE CARD AT FRONT

INSURANCE CO.__________________

____

SUBS ID#________________________

SUBS NAME______________________

GROUP#_________________________

FINANCIAL AND BILLING POLICY AGREEMENT

I authorize treatment of my spouse & dependent children. I agree to pay all fees & charges for my and their treatment, at time of service. If my insurance or Medicare does not cover certain covered charges or does not pay in a timely manner, I understand I am responsible for payment in full for all charges. I am responsible to find out why my insurance company is not paying. I authorize payment of all insurance benefits to Shivinder S. Deol MD Inc. DBA Anti-Aging & Wellness Center for all services provided. I authorize release of information to my insurance company & appropriate agencies per HIPAA. I understand that if my account is turned over to collection, there will be $25.00 fee in addition to the monthly finance charge of 18% per annum. If I consent to buy any supplies, or have any uncovered or medically unnecessary procedures done, then i will be responsible to pay for these charges at time of service. These uncovered services are not billed to Medicare / insurances.

SIGNATURE____**DATE**________________

PATIENT / PARENT / OR RESPONSIBLE PARTY (PRINT NAME)