HOWARD HOLTZ, LLC

Howard Holtz, M.D. Jacquelin Holubka, M.D.

DATE: ________________

1/2017

PATIENT INFORMATION			
Patient Last Name, First Name & Middle Initial	Date of Birth	Age	Social Security Number

Patient Address

Town State Zip

Patient Home Phone Number	Patient Work Number Ext	Patient Cell Phone Number

Please indicate preferred contact number: ☐ Home ☐ Work ☐ Cell	Email:

Occupation:

Race:

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander

☐ White ☐ Other ☐ Unknown ☐ Prefer not to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Other ☐ Prefer not to answer	Preferred Language: ☐ English ☐ Spanish ☐ Other

Patient Relationship To Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other	Patient is: ☐ Single ☐ Married ☐ Widowed ☐ Other	Patient Sex: ☐ Male ☐ Female

Emergency Contact:	Telephone Number	Relationship

How did you hear of our practice?

☐ Doctor Name: ____

☐ Family/Friend ☐ Insurance ☐ Internet ☐ Returning Patient ☐ Social Media ☐ Street Sign/Ad ☐ Yellow Pages

Please list other family members who have been seen at the practice:

INSURANCE INFORMATION – THIS SECTION MUST BE FULLY COMPLETED

Name of Primary Insurance Carrier	Policy Number	Group Number
Policy Holder Name on Primary Plan	Policy Holder Date of Birth	
Name of Secondary Insurance Carrier	Policy Number	Group Number
Policy Holder Name on Secondary Plan	Policy Holder Date of Birth	

HEALTHCARE INFORMATION

Preferred Pharmacy	Tel Number	Town

I acknowledge receipt and understand the HIPAA privacy laws as they pertain to Howard Holtz, LLC.

Patient/Guardian Signature____ Date:_______________

GUARANTOR FINANCIAL AGREEMENT- PARTICIPATING INSURANCE PLANS

I authorize the release of information necessary to any entities to secure the payment of benefits submitted for services rendered by Howard Holtz, LLC on behalf of myself and/or dependents. I understand information will be provided to a contracted billing service, Advanced Electronic Medical Billing, Inc., to secure the payment of benefits. I further agree and acknowledge that my signature on this document authorizes claims to be submitted for benefits for any services rendered without obtaining my signature on every claim form. I assign directly to Howard Holtz, LLC insurance payments for all services rendered. Should the need arise, I also authorize Howard Holtz, LLC and Advanced Electronic Medical Billing, Inc., to file any dispute/appeal regarding fair payment.

I understand I am financially and fully responsible for all charges incurred if my insurance carrier denies payment for any reason. I understand I will be financially responsible for any deductibles, coinsurance or co-pays that my insurance plan states I owe. I understand that a co-payment is due at the time of service. I understand that a delinquent balance must be paid in full prior to any scheduled appointments, unless prior payment arrangements have been made. I understand I am responsible for contacting my insurance carrier prior to services rendered, to determine participation, referral or pre-authorization requirements, and coverage limits. In the event my insurance carrier issues a payment to me, I agree to promptly reimburse Howard Holtz, LLC the same amount in addition to any patient responsibility indicated on the benefit statement, which must be sent with my payment.

An appointment time has been allocated to you, and is not available for other patients. A change of appointment must be re-scheduled with our office at least one week prior to your appointment. We require 24 hours advance notice of all cancellations. A charge of $50.00 will be incurred if an appointment is not cancelled within 24 hours advance notice. Reminders calls are a courtesy, it is your responsibility to remember your appointment.

I agree to provide current insurance information and notify the office of any changes within 30 days from my visit. I understand that if a claim is not paid because of my failure to provide the correct insurance information in a timely manner, I am fully responsible for the charges. I understand that payment is due upon receipt of my monthly statement, which will reflect a brief description of services provided. I understand that I may be legally responsible for all collection costs involved including but not limited to attorney's fees that are 1/3 of all balances due and owing, collection filing fees, and any fees for returned checks. Any credits will remain on your account and will be applied to future balances, unless you contact our billing department and request a refund in writing.

GUARANTOR FINANCIAL AGREEMENT- NON-PARTICIPATING INSURANCE PLANS

Our practice participates with CMS Medicare Part B. We do not participate with Medicare Managed Care HMO replacement or any commercial insurance plans. I understand payment is due at the time of service, and a claim will be submitted to my insurance as a courtesy. In the event my insurance carrier issues a payment directly to me and no payment was collected at the time of visit, I agree to promptly reimburse Howard Holtz, LLC the same amount in addition to any co-pays, deductibles or coinsurances due based on the explanation of benefits, which must be sent along with my payment.

Please sign below

PATIENT /GUARANTOR SIGNATURE (Must be 18 Years of Age) Date:

Please print full name:		**Daytime Telephone:**
Please print full mailing address:		
Town	**State**	**Zip code**

This agreement is independent /separate from a medical service agreement. This agreement has no term date and will remain in force until such time as a new agreement is signed.