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### Patient Information

Name \_\_\_\_\_ Email \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_  
Social Security No. \_\_\_\_\_ Date of Birth \_\_\_\_\_ Primary Dr. \_\_\_\_\_  
Employer \_\_\_\_\_ Address \_\_\_\_\_  
Occupation \_\_\_\_\_ In case of emergency, contact \_\_\_\_\_ Phone \_\_\_\_\_

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### Insurance Information

Circle one: Health Ins. Auto Ins.

Name of person Insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_

**\*\*Please provide us with any/all insurance cards so that we may copy them for your file as well as verify any benefit information.**

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### Credit card information

Please provide us with credit card information.

Card #: \_\_\_\_\_ Exp. Date \_\_\_\_\_ Circle one:  Visa  Master Card

**\*\*Please provide us with a card so that we may copy for your file.**

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### Supplementary Information Circle one

Is injury employment related?, (workers' comp. claim): Yes No Date injured: \_\_\_\_\_

Marital status: Single Married Divorced Widowed

Is care accident related? (Non-auto): Yes No

Is care auto accident related? Yes No

Employment Status: Full time Part time Retired Non-employed

Any past history of similar symptoms? Yes No

Student status: Full time Part time Non-student

Is this an emergency?: Yes No

If yes, please describe: \_\_\_\_\_

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### Referral Source

Whom may we personally thank for your referral? \_\_\_\_\_

Referred by: Attorney Doctor Work/Company Patient Other: \_\_\_\_\_

Please give us the name and telephone number of any friends or relatives who you think may benefit from our services or would like a free consultation:

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## Our Office Policy on Payment

Please note that payment is due when services are rendered unless other arrangements are made in advance. If you are unable to pay in full today, a partial payment or co-payment is expected. If you have insurance, we will take assignment of benefits from your insurance company if possible and we will do all that we can to arrange for payment directly by your insurance company to us. We are **not** responsible for collecting your insurance or for negotiating any settlement on a disputed bill. We will work with you on insurance problems. You will still be responsible for deductibles and co-payments **at the time of service** in accordance with your particular insurance company. If on insurance verification we are informed that specific services are not covered, for which we are later paid by your carrier, *we reserve the right to retain any monies paid by your insurance company for services you did not pay for.* **You are responsible for your bill.** Finance charges will accrue at 1.5% monthly on unpaid balances and you will be responsible for any collection fees. You will be charged for office visits not cancelled with at least 24 hours notice.

By signing below, I indicate that I have read and fully understand this agreement and all the payment responsibilities contained herein, and agree to abide by them. Additionally, I understand that Dr. Scopelliti will be forwarding my examination, my diagnosis, and his recommendations in an initial report to any and all attending physicians including your primary care physician.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Assignment of Benefits

I authorize payment of medical benefits to the named provider for professional services rendered.

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

### Release of Information

I authorize the release of any medical information to any and all treating doctors, and any relative insurance companies.

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

I have read the MCNC HIPPA policy, and understand and agree to it.

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

### Insurance verification: (For Office Use Only)

Please reference verification of benefits form.

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