Prompt Primary Care
8750 SW SR 200, Suite 102
Ocala, FL 34481
(352) 861-5444 Tel
(352) 861-5447 Fax
www.promptprimarycare.com

New Patient Information Sheet

ACCOUNT #

LAST NAME (PLEASE PRINT) FIRST NAME MI	SOCIAL SECURITY #	AGE	SEX	BIRTH DATE	MARITAL STATUS
STREET ADDRESS (PERMANENT)	CITY AND STATE			ZIP CODE	HOME PHONE #
E-MAIL ADDRESS (ALLOWS US TO SEND UPDATES & INFORMATION. YOU MAY GET OUT ON ANYTIME).				FAX #	CELL PHONE #
EMPLOYER/SCHOOL	OCCUPATION (INDICATE IF STUDENT)			HOW LONG EMPLOYED	BUSINESS PHONE #
EMPLOYER'S STREET ADDRESS	CITY AND STATE			ZIP CODE	LOCAL PHONE
SPOUSE OR PARENT'S NAME	SOCIAL SECURITY #				BIRTH DATE
SPOUSE OR PARENT'S EMPLOYER	OCCUPATION		HOW LONG EMPLOYED		BUSINESS PHONE #
EMPLOYER.S STREET ADDRESS –	CITY AND STATE				ZIP CODE
HAVE YOU OR ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED HERE?	WHO?		REFERRED BY:		

All Payments, deductibles and co-payments are due at the time of service.

INSURANCE AUTHORIZATION AND ASSIGNMENT AND CONSENT OF TREATMENT

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE ON MY BEHALF TO PROMPT PRIMARY CARE OF OCALA FOR ANY SERVICES FURNISHED TO ME BY THAT PHYSICIAN. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE TO RELATED SERVICES.

I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IF ITEM 9 OF THE HCFA 1500 CLAIM FORM IS COMPLETED, MY SIGNATURE AUTHORIZES RELEASING OF THE INFORMATION TO THE INSURER OR AGENCY SHOWN. IN MEDICARE ASSIGNED CASES, THE PHYSICIAN OR SUPPLIER AGREES TO ACCEPT THE CHARGE DETERMINATION OF MEDICARE AS THE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, COINSURANCE, AND NONCOVERED SERVICES. COINSURANCE AND THE DEDUCTIBLE ARE BASED UPON THE CHARGE DETERMINATION OF MEDICARE.

I UNDERSTAND ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS, HOWEVER, THE PATIENT IS ULTIMATELY RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. ALL FEES STILL PENDING WITH INSURANCE COMPANIES AFTER SIXTY DAYS WILL BE THE RESPONSIBLITY OF THE PATIENT.

SIGNATURE: _____ DATE: _____

Payment is Due at the time of service, unless we file your insurance

METHOD OF PAYMENT: ☐VISA ☐MASTERCARD ☐CASH ☐CHECK ☐INSURANCE ☐W/C

NAME OF INSURANCE COMPANY: _____

NAME OF SUPPLEMENTARY INSURANCE COMPANY (IF ANY) _____

CONSENT FOR TREATMENT

DATE	TIME	SIGNATURE	DATE	TIME	SIGNATURE