Meagan W. Shepherd Allergy, PLLC

Date _____

6007 Rt. 60 East, Suite 130, Barboursville, WV 25504
Phone: 304-733-3333/Fax: 304-733-3666

(Please Fill Out Completely)

Patient's Name _____
Last First Middle

Mailing Address _____
Street City/State Zip Code

E-MAIL ADDRESS_____

Date of Birth _____ Age _____ ☐ Male ☐ Female Marital Staus: S☐ M☐ D☐ W☐

Social Security Number _____ Cell Phone _____ Home Phone _____

Employer _____ How long: _____ Occupation _____ Work Phone_____

Person Responsible for Account _____ Relationship to Patient _____
(If not above named)

Address _____Phone _____
(If not listed above) Street City/State Zip Code

Referred By _____
Name Address City/State Zip Code

Family Physician _____
Name Address City/State Zip Code

In Case of Emergency, contact _____Phone _____

Do we have your permission to: Leave a message regarding your appointments on your answering machine at home? ☐ Yes ☐ No

Leave a message regarding your appointments at your place of employment? ☐ Yes ☐ No

How did you hear about our practice? _____

****Please present your <u>insurance card</u>(s), <u>prescription card</u>, and <u>photo identification</u> to the receptionist for scanning.****

Primary Insurance Carrier _____ Group No. _____

Policy Holder's Name _____Date of Birth _____ Identification No. _____

Secondary Insurance Carrier _____ Group No. _____

Policy Holder's Name _____ Date of Birth _____ Identification No. _____

MEDICARE PATIENTS: This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for consideration of a claim. Please read and sign the following statement.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _ _____
Signature as it appears on Medicare Card **Date**

If you have a supplemental policy and it is a **MEDIGAP** policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file. Please read and sign the following statement.

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Signature as it appears on MEDIGAP Card **Date**

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical information necessary to process my claims and request payment of medical benefits either to myself or to the party who accepts assignment. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

_____
Signature of Insured or Authorized Person **Date**

If Dr. Shepherd does not participate with my insurance company, I understand I am responsible for payment at the time of service.

_____
Signature of Patient (or Guardian) **Date**

If there is an emergency that requires an ambulance or emergency medical services, I understand I and/or my insurance are responsible for payment.

_____
Signature of Patient (or Guardian) **Date**