

Paul F. Brillhart, M.D., A.B.F.P.
Family Health Care of Post Falls

Have you been seen by Paul F. Brillhart, M.D. before? **YES** **NO**

Referred by: _____

PATIENT INFORMATION:

Last Name: _____ **First Name:** _____ **Middle Name:** _____

Street Address: _____ **Mailing Address:** _____

City: _____ **ST:** _____ **Zip:** _____ **Home Phone:** _____

Employer: _____ **Work Phone:** _____

Date of Birth: _____ **Age:** _____ **Social Security #:** _____ **Sex:** **M** **F**

Marital Status: **S** **M** **W** **D** Spouse's Name: _____ Spouse SSN _____

If patient is a minor, parent/guardian name: _____

Nearest friend or relative not living with you: _____ Phone #: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____

Visa #: _____ Exp. Date: _____ MasterCard #: _____ Exp. Date: _____

FINANCIAL ARRANGEMENTS: _____ **CASH** _____ **INSURANCE**

(Copy of insurance card is required for billing purposes)

Primary Insurance Name: _____

Subscriber's Name: _____ Subscriber's birthdate: _____

Subscriber #: _____ Group #: _____ Insurance Phone: _____

Secondary Insurance Name: _____

Subscriber's Name: _____ Subscriber's birthdate: _____

Subscriber #: _____ Group #: _____ Insurance Phone: _____

NAME AND ADDRESS OF PERSON/AGENCY RESPONSIBLE FOR BILLING:

Phone #: _____

AUTHORIZATION:

- All of the above information is true to my knowledge.
- I authorize this office to release the named insurance company or attorney any information necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage.
- I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
- I authorize and request that insurance payment be made directly to Family Health Care of Post Falls should they elect to receive such payment.
- I authorize Family Health Care of Post Falls to leave a message with my family or on my answering machine reminding me about my upcoming appointment.
- After insurance settlement, accounts will be subject to a finance charge at the periodic rate of 1.5% per month, which is an APR of 18%, not including Medicare and Medicaid.

PATIENT/PARENT SIGNATURE _____ **DATE** _____