CarolinaEast Internal Medicine and Pediatrics

MRN______________

Patient Name: (Last, First, MI):___________________________ DOB:____________________ Sex: M F Race: _______

SSN:_____________________ Home Phone:____________________ Primary MD:______________________________

Cell Phone: ______________________ Email Address: ________________________________ Marital Status: __________

Mailing Address (P.O. Box): _______________________________ City: _____________ State: _______ Zip: __________

Physical Address: ____ City: _____________ State: _______ Zip: __________

Employer:_____________________________________ Phone:____________________ Retired / Unemployed

Spouse/Parent/Guardian Name (Last, First, MI):_____________________________________ DOB: ___________________

Spouse/ Parent/Guardian Employer (If any):_________________________ Work phone: ____________________________

Spouse/Parent/Guardian Phone Number: ___________Cell phone: _______________ Email: __________________________

Emergency Contact:_____________________________ Phone:____________________ Relationship: ________________

INSURANCE INFORMATION

Primary: _______________________________ Policy Holder: ____________________________ DOB: _______________

Secondary_______________________________ Policy Holder: ____________________________DOB:_______________

Tertiary (3rd):_______________________________ Policy Holder: _________________________DOB: _______________

BENEFICIARY AGREEMENT

Consent for Examination: "I hereby voluntarily present myself to CarolinaEast Physicians for examination, treatment, and medical or nuclear procedures and do hereby consent to medical services as may be deemed necessary by my physician here at CarolinaEast Physicians."

Release of Information: "I authorize CarolinaEast Physicians to:

a. Release any information needed to determine medical necessity and payment of benefits to my insurance carrier.
b. Release requested medical information that relates to my treatment here to my referring Physicians or ________________________

For all patients not covered by Medicare or other governmental program:

1. "I assign and authorize CarolinaEast Physicians to submit a claim to my insurance carrier(s) for all covered services rendered by their physicians and DIRECT MY INSURANCE CARRIER (S) OR THEIR AGENT (S) TO PAY CAROLINAEAST PHYSICIAN."
2. "I understand that I am financially responsible for any & all charges not met by the proceeds of this assignment and for all charges or should said proceeds not be paid in a reasonable time after charges are file with the carrier, or should the carrier deny or reduce payment below CarolinaEast Physicians charge. I understand that I will be legally responsible for all collection costs ($25.00) involved with the collection of this account including all court costs, reasonable attorney fees, and all other expenses incurred with collection if I default on this agreement."
3. "I am hereby notified by CarolinaEast Physicians that insurance carriers will deny payment for routine exams or test where there are no symptoms or positive findings. They can also determine that certain exams and tests are not 'medically necessary'."

For all patients covered by Medicare, Medicaid, Medigap, Tricare or other government programs:

1. "I request payments of authorized benefits be made on my behalf by Medicare, Medicaid, Medigap, Tricare or other governmental agency is paid directly to CarolinaEast Physicians for medical services furnished to me by their physicians. I understand that I am responsible for any deductible and coinsurance of allowable charges not otherwise covered."
2. "I am hereby notified by CarolinaEast Physicians that the above carriers or agencies may deny payment for routine exams and procedures that are not medically necessary, and that I agree to be personally responsible in such cases."

________________________________ ________________ ____________

SIGNATURE **RELATIONSHIP** **DATE**