JAMES T. MARTIN, JR., MD

PLEASE COMPLETE ALL SECTIONS

Patient Information

Dr. James T. Martin, Jr., M.D. Rebecca Miller, PA-C Martha Green, PA-C

Today's Date: ______________________________

Social Security Number: _________-_________-_________ Date of Birth: _________/_________/_________

Title (Ms., Miss., Mrs., Dr.) _____________

Last name: ______________________________ First name: ______________________ Middle Initial: ________

What name do you preferred to be called? ____

Address: ____ Apt # ______________

City: ________________________ State: ___________ Zip code: ___________ County: _________________

Home phone: ( ) _________-_________ Cell phone: ( ) _________-_________ Email: __________________

Mailing Address: (if different than above address)

____ Apt # ______________

City: ______________________________ State: ________________ Zip code: __________________

Race: ___________ Marital Status: (please circle one) Single - Married - Divorced - Separated - Widow

Student Status: (please circle one) None - Full Time - Part Time

Employment Status: (please circle one)
Not Employed - Full Time - Part Time - Self Employed - Military - Active Duty - Retired

Employer Name: ____

Work Phone: ( ) __________-__________ Ext.__________ OK to Call? Yes________ No _________

Spouse's Name: ______________________________ SSN: ______-______-______ DOB: ______/______/______

Spouse's Employer: ____ Work Phone: ( ) ________-________

Emergency Contact: ____ Phone: ( ) ________-________

Referred by: ____ Phone: ( ) _________-_________

Primary Doctor: ____ Phone: ( ) _________-_________

Pharmacy: ____ Phone: ( ) _________-_________

PLEASE READ, READ, READ ALL THIS INFORMATION.

Note: Accurate insurance information is vital for your financial responsibility to this office and correct scheduling of subsequent test or procedures. If insurance information is incorrect, we will require collection of payment in full at the time of service(s); and subsequent scheduling of tests or procedures may be affected.

ALL INFORMATION HAS TO BE FILLED OUT BELOW

Primary Insurance Information: (If Other Is Circled, Complete Additional Information)

Insured Relationship to Patient: (please circle one) Self or Other ______________________________

Insurance Name: ____

Name of Insured: ____

Secondary Insurance Information: (If Other Is Circled, Complete Additional Information)

Insured Relationship to Patient: (please circle one) Self or Other ______________________________

Insurance Name: ____

Name of Insured: ____

Insurance Cards Available to Scan: Yes ____________ No ____________

ALL INFORMATION HAS TO BE FILLED OUT BELOW

The primary insured person's name: ____

The home address of insured person: ____

The home phone number of insured person: ( ) ________/____________ Work number of insured person: ( )_______/________________

Cell phone number: ( )_________/__________________ The SS# _________-__________-___________ DOB: ________/________/________

The secondary insured person's name: ____

The home address of insured person: ____

The home phone number of insured person: ( ) _________/____________ Work number of insured person: ( ) ________/_______________

Cell phone number ( ) ________/__________________ SS# _________-__________-____________ DOB: ________/________/_________

Who is the person this office needs to bill: ____

INSURANCE AUTHORIZATION AND ASSIGNMENT: (PLEASE READ ALL THIS INFORMATION)

I do hereby authorize D. James T. Martin, Jr., M.D. and/or staff to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am to immediately notify Dr. James T. Martin's office if any changes occur in my insurance. Payment is expected at time/date of service.

All professional services rendered are charged to the patient. There will be a charge of $10.00 for NSF checks if turned over to a collection agency. If not turned over to a collection agency, you will be charged $35.00 for an NSF check.

If surgery or in-office surgical procedures are indicated, the patient is responsible for furnishing insurance claims to the office prior to surgery and the patient is responsible for paying in-advance in full before any procedure is done. In the event of Surgery/Procedure needing scheduled, please review: we will reschedule your surgery/procedure 1 time with a valid excuse. After this there could be a minimum fee of $50.00 applied to your account, which would be patient responsibility. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance. If this account has to be turned over to collection, the undersigned grantor (parent or guardian, if patient is a minor or going to college and of age) agrees to pay all legally allowed interest and all collection and attorney's fees. There is a $10.00 per form fee for disability, worker-compensation, FMLA forms etc. Obtaining/copying of medical records requires a $15.00 administration fee, 0.65 per page charge after the 15th page and postage will be expected when records are released. Dr. James Martin's office requests a 24 hour cancellation notice of a scheduled appointment. After the 3rd no show appointment without prior cancellation, there may be a $25.00 no show fee added to the patient's account. Rates/fees subject to change without notice.

I understand that insurance is filed as a courtesy and that any charges not covered by my insurance will be the responsibility of the above-designated person.

I further understand that I will be responsible for any collection and/or legal fees and monthly interest accrued due to non-payment. Accrued interest rate = 18% per year.

Patient's Signature: ____ Date: ____________________

If patient under the age of 18, person financially responsible signature: ______________________________________ Date: ____________________

Relationship: ______________________________________