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Referring Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s date\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_

WHAT PHARMACY DO YOU NORMALLY USE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(We will contact your pharmacy to verify the name and strength of your medications unless otherwise instructed)

**Patient Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_/\_\_\_\_\_\_ /\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_\_\_

Social Security #\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_ Marital Status: Married \_\_\_\_ Single \_\_\_\_ Widowed \_\_\_\_ Other ***\_\_\_\_***

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance **(Primary**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance (**Secondary**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grp#\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grp#\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your relationship to policy holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your relationship to policy holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Date of Birth\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_Policy Holder Date of Birth \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Policy Holder SSN \_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_ Policy Holder SSN \_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_

(must have Date of Birth and SSN to file a claim) (must have Date of Birth and SSN to file a claim)

**ETHNICITY:** Hispanic or Latino \_\_\_\_ Non-Hispanic or Latino \_\_\_\_ Multiethnic \_\_\_\_Refuse to Report \_\_\_\_

**RACE:** White \_\_\_\_ Black or African American \_\_\_\_ Asian \_\_\_\_ American Indian or Native Alaskan \_\_\_\_

Native Hawaiian or Pacific Islander \_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Refuse to Report \_\_\_\_

**PREFERRED LANGUAGE**: English \_\_\_\_ Spanish \_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By signing below, you agree that all information you have provided on the form above is correct to the best of your knowledge**

This signature below will also give us consent to call you at any number provided to us above.

Patient Signature/Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Today’s Date:** \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

This is a confidential record: Please answer the following questions as completely as you can. If you are uncertain about a question, leave it blank. Information contained here will not be released without your authorization.

Were you referred by a physician? NO \_\_\_\_YES\_\_\_\_ Name of physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What symptoms/problems prompted this visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other physicians you have seen for this problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you had your problem? Years \_\_\_\_\_\_\_\_\_\_\_\_Months \_\_\_\_\_\_\_\_\_\_\_Days \_\_\_\_\_\_\_\_\_\_\_\_\_

**If you have pain:**

Where does it hurt? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How severe is it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long has it hurt? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When does it hurt? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does it hurt? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What makes it hurt? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes it hurt less? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What other signs or symptoms do you have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATION ALLERGIES OR SIDE EFFECTS TO MEDICATIONS**:

Drug/Medication Location (skin, local, abdominal, systemic) Severity (mild, moderate, severe)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS YOU ARE TAKING**: This list must include **ALL** known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medication’s name, dosage, frequency and route of administration.

1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ARE YOU CURRENTLY UNDER CONTRACT WITH A PAIN SPECIALIST?** No \_\_\_\_ Yes \_\_\_\_

Pain Specialist Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ARE YOU PRESENTLY BEING TREATED OR HAVE YOU BEEN TREATED FOR ANY OF THE FOLLOWING:** (Insert Year)

\_\_\_\_\_ Heart Attack \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Atrial Fibrillation \_\_\_\_\_ Bleeding Tendency

\_\_\_\_\_ Anemia \_\_\_\_\_ Mitral Valve Prolapse \_\_\_\_\_ Stroke or Paralysis \_\_\_\_\_ Diabetes

\_\_\_\_\_ COPD \_\_\_\_\_ Hepatitis \_\_\_\_\_ Kidney Disease \_\_\_\_\_ Thyroid Problems

\_\_\_\_\_ Cancer (type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Other Illness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIOR SURGERIES**: (Including outpatient procedures)

**YES NO** YEAR/PLACE/PHYSICIAN

Tonsillectomy \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appendectomy \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hernia Repair \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gallbladder removal \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hysterectomy \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hemorrhoidectomy \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Bypass \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast Surgery \_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Today’s Date:** \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

**COLONOSCOPY HISTORY:**

If over the age of 50, have you had a colonoscopy within the last 10 years? NO \_\_\_\_ YES \_\_\_\_

Which physician preformed the colonoscopy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What Year? \_\_\_\_\_\_\_\_\_

Do you have any family history of colon cancer? NO \_\_\_\_ YES \_\_\_\_ What was their relation to you? \_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**  Have any of your blood relatives ever had any of the following diseases?

Heart Disease \_\_\_\_\_\_\_\_\_\_\_\_ Stroke \_\_\_\_\_\_\_\_\_\_\_\_ Arthritis/Gout \_\_\_\_\_\_\_\_\_\_\_\_

Hypertension \_\_\_\_\_\_\_\_\_\_\_\_ Diabetes \_\_\_\_\_\_\_\_\_\_\_\_ Lung Disease \_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis \_\_\_\_\_\_\_\_\_\_\_\_ Cancer (type) \_\_\_\_\_\_\_\_\_\_\_\_ Kidney Disease \_\_\_\_\_\_\_\_\_\_\_\_

**OCCUPATIONAL/SOCIAL HISTORY**

Present Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If disabled, please explain why\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke or use tobacco products? NO\_\_\_\_ YES\_\_\_\_ Packs/day\_\_\_\_\_\_\_\_\_\_\_\_ Number of Years\_\_\_\_\_\_\_\_\_

Have you ever used tobacco products in the past? NO\_\_\_\_ YES \_\_\_\_ When did you quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol use? Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Socially \_\_\_\_\_ Never \_\_\_\_\_

Type: Beer \_\_\_\_\_ Wine \_\_\_\_\_ Liquor \_\_\_\_\_

**REVIEW OF SYSTEMS**: please circle for “Yes” for any that apply to you currently

**CONSTITUTIONAL:** Fever Weight gain (amount\_\_\_\_lbs.) Weight loss (amount\_\_\_\_lbs.) Exercise tolerance

**EYES:** Dry eyes Irritation Visual changes

**EAR, NOSE, THROAT:** Difficulty hearing Ear pain Nose bleeds Sinus pain Sore throat Snoring

Bleeding gums Dry mouth Teeth problems

**CARDIOVASCULAR:** Chest pain on exertion Arm pain with exertion Shortness of breath when walking

Shortness of breath when lying down Palpitations Heart murmur Lightheaded when standing

**RESPIRATORY:** Cough Wheeze Shortness of breath Coughing blood Sleep apnea

**GASTROINTESTINAL:** Abdominal pain Vomiting Change in appetite Black or tarry stools Diarrhea

Reflux/heartburn Vomiting blood GERD

**GENITOURINARY:** Incontinence Difficulty urinating Blood in urine Increased urinary frequency

Incomplete emptying

**MUSCULOSKELETAL:** Muscle aches Weakness Joint pain Back pain Swelling in extremities

**INTEGUMENTARY:** Abnormal mole Jaundice Rash/itching Dry skin Growths/lesions Laceration

**NEUROLOGIC:** Loss of consciousness Weakness Numbness Seizures Dizziness

Headaches Restless legs

**PSYCHIATRIC:** Depression Sleep changes Restless sleep Alcohol abuse

**ENDOCRINE:** Fatigue Increased thirst Hair loss Increased hair growth Cold intolerance

**HEMATOLOGIC/LYMPHATIC:** Swollen lymph nodes Easy bruising Excessive bleeding

**ALLERGIC/IMMUNOLOGIC:** Runny nose Sinus pressure Itching Hives Frequent sneezing

**BREAST:** Perform monthly self-breast exams Yearly mammograms

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**Specific Authorization for Family Member/Friend**

I, direct my health care and medical services providers and payers to disclose and release my protected health information to:

Name Relationship Contact Information

This authorization shall be effective until (check one):

\_\_\_\_\_\_\_ All past, present, and future periods, OR

\_\_\_\_\_\_\_ Date or Event: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

unless I revoke it (NOTE: You may revoke this authorization in writing at any time by

notifying your health care provider, preferably in writing.)

Name of Individual Giving this Authorization Date of Birth

Signature of Individual Giving this Authorization Date

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**Important Notice**

**Notice of Charge for Completion of Forms**

Beginning February 1, 2001, we will require payment for the completion of forms you ask us to complete on your behalf. We receive many requests for completion of these forms. This requires extra work, time, and financial resources in excess of what is normally needed to complete the medical record.

*We will make every effort to complete these forms within 5 business days, however, we cannot make any assurance of completion within your time frame(s).*

*Payment is required prior to completion of the form(s).*

***A charge of $10 per form applies to completion of the following forms:***

* Disability and Family Leave Medical Act
* Personal disability insurance forms
* Loan payment forms
* Credit insurance forms
* Other insurance policy forms that make loan payments in the event of disability
* Unemployment insurance forms

***A charge of $20 applies to the completion of the above forms if completion is required in 24 hours or less.***

There will not be a charge to complete regular insurance claim forms for payment of services to our clinic for visits and/or surgical procedures by your health insurance company.

The following forms will be completed at no charge to the patient:

* Application for public assistance forms
* Worker’s Compensation forms
* Social Security Administration

**Instructions:**

Payment is required prior to completion of the form(s).

* We are not obligated to complete these forms but do so as a courtesy to you. We reserve the right to refuse to complete any forms you present to us for completion.
* Please submit your request for completion of forms well in advance of when they are needed. We will attempt to complete the forms as quickly as possible; however, in order to properly address them we need adequate time to review your records.
* Please make sure that all of your information is completed on the form before you give it to us.
* Do not complete the section(s) of the form that are required to be completed by our office.
* Forms which require comprehensive review of patient records, analysis, and a detailed response may be charged a higher fee. We will inform you of these charges at the time the services are requested.

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AUTHORIZATION OF TREATMENT: I GIVE AUTHORIZATION TO DR. MCCOLGAN FOR MEDICAL TREATMENT.

AUTHORIZATION FOR RELEASE OF INFORMATION: I AUTHORIZE DR. MCCOLGAN TO SUBMIT ANY INFORMATION NEEDED BY MY INSURANCE COMPANY OR COMPANIES TO FACILITATE PAYMENT OF CLAIMS.

I AUTHORIZE DR. MCCOLGAN TO RELEASE MY INFORMATION TO THE HOSPTIAL AND/OR SURGERY CENTER FOR SCHEDULING SURGERY OR TESTS, OR A REFERRING PHYSICIAN FOR SCHEDULING AN APPOINTMENT.

CONFIDENTIALITY: I UNDERSTAND DR. MCCOLGAN USES THIRD PARTIES OR MEDICAL TRANSCRIPTION, ACCOUNTING AND CLEANING SERVICES. THESE COMPANIES HAVE AN AGREEMENT TO KEEP ALL PATIENT INFORMATION CONFIDENTIAL. I UNDERSTAND THE OFFICE OF DR. MCCOLGAN MAY CALL MY HOME AND/OR WORK PHONE NUMBER TO CONFIRM OR RESCHEDULE APPOINMENTS AND/OR TO DISCUSS MY BILL OR INSURANCE ISSUES WITH ME. THEY MAY LEAVE A MESSAGE AT MY HOME OR WORK UNLESS OTHERWISE INSTRUCTED BY ME. I UNDERSTAND THAT I HAVE THE RIGHT TO ASK THAT SPECIFIC PERSONS NOT BE PRIVY TO ANYTHING REGARDING MY PHI. THIS REQUEST MUST BE ISSUED TO DR. MCCOLGAN’S OFFICE IN WRITING.

I WILL INFORM DR. MCCOLGAN’S OFFICE IF MEMBERS OF MY IMMEDIATE FAMILY MAY NOT BE INFORMED OF MY MEDICAL CONDITION.

ASSIGNMENT OF BENEFITS: I AUTHORIZE MY INSURANCE COMPANY TO MAKE PAYMENT DIRECTLY TO DR. MCCOLGAN ON MY BEHALF. I ALSO REALIZE I AM RESPONSIBLE TO PAY ANY DEDUCTIBLE AND COPAYMENT AND/OR COINSURANCE AMOUNTS STATED BY MY POLICY. I HAVE READ AND UNDERSTAND THE BILLING AND COLLECTIONS POLICY FOR WILLIAM L. MCCOLGAN, III, M.D., P.A. AND AGREE TO ITS ENFORCEMENT. IF PAYMENT IS NOT RENDERED IN A TIMELY MANNER (UNLESS OTHER ARRANGEMENTS ARE MADE) AND MY ACCOUNT IS SENT TO COLLECTIONS, I WILL BE RESPONSIBLE FOR ALL ATTORNEY FEES, COURT FEES, AND/OR COLLECTION FEES, NOT TO EXCEED 35%.

I UNDERSTAND THAT I WILL BE CHARGED ADDITIONAL FEES FOR COMPLETION OF FORMS OTHER THAN MY NORMAL HEALTH INSURANCE CLAIM FORM.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

PATIENT OR GUARANTOR SIGNATURE DATE