HighDesertClinic
URGENT AND OCCUPATIONAL CARE

(Please Print Clearly and Complete Entire Form)

Patient Name:_____ **Date of Birth:**_____

Social Security #: _____ **Gender:** o M o F

Mailing Address_____City _____ State _____ Zip _____

Physical Address_____ City _____ State_____ Zip _____

Phone Numbers: Main _____ Alt _____

Email Address_____ o Married o Single o Widowed o Divorced

Race/Ethnicity: o Hispanic o Black o White o Asian o American Indian o Pacific Islander o Other

Preferred Language* _____

Reason for Today's Visit _____

How you heard about us: o Friend o Relative o Work o School o Newspaper o Phonebook o Radio o TV o Doctor Referral o Internet o Other

Employer Name _____

Employer's address _____ Phone#_____

Responsible Party (**Policy Holder of Insurance AND/OR Guarantor if Patient is Under 18):**

Name: _____ Relationship: _____

Date of Birth:_____ Social Security#:_____

Address _____ Phone#: _____

Employer _____

Insurance Information- Please Give All Insurance Cards to the Receptionist for Scanning

Primary Insurance_____ Id Number _____

Secondary Insurance _____ Id Number _____

Who should we contact in an emergency?_____ Phone _____

*For documentation only. We may not be able to accommodate your preferred language.

TURN PAGE!!!

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PATIENT FINANCIAL RESPONSIBILITY

At High Desert Clinic we accept many insurance plans. However, it is the patient's responsibility to ensure that his or her benefit eligibility as benefit options vary. Therefore, all patients are encouraged to verify benefit eligibility prior to seeking care at High Desert Clinic.

Authorization to pay: I hereby authorize payment directly to the business office of the physician/clinic for surgical and/or medical benefits, if any otherwise payable to me for services.

I understand that if I have a copay, it is due at the time service is rendered. I will be responsible for any additional expenses this office may incur in the collection of an outstanding balance on my account. If it becomes necessary to forward your account to our collection agency, an additional 35% fee will be added to your balance and we will refuse service until balance is paid in full.

We are unable to accept checks at this facility. If you submit payment to our billing office by check and it is returned for insufficient funds, there will be an additional $25.00 fee.

High Desert Clinic will charge a $25.00 fee for any disputed valid credit card transaction.

_____ _____

Patient or Guardian Signature Date