



CLIENT INFORMATION

Name: _____ Today's Date: _____

Address: _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone:() _____ Work/Other Phone: () _____

Date of Birth: _____ Age _____ Social Security # _____

Driver's License # _____ Single _____ Married _____ Divorced _____ Widow _____

Client Employer: _____ Phone/Extension: _____

Occupation: _____

Spouse's/Sig. Other/Guardian: _____ Phone: _____

Relationship to you: _____ Address (if different than yours): _____

City: _____ State: _____ Zip: _____ Employer: _____

Occupation: _____ Phone: _____ Extension: _____

PRIMARY CARE PHYSICIAN: _____ Referred by: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone: _____

INSURANCE INFORMATION:

***PRIMARY INSURANCE COVERAGE**

Insurance Name _____

Policy Holder Name _____

Relation to You _____

Date of Birth _____

Social Security # _____

Policy ID # _____

Group # _____

Co-Payment \$ _____

Effective/Termination Dates _____ / _____

***SECONDARY INSURANCE COVERAGE
(OB CARE ONLY)**

Insurance Name _____

Policy Holder Name _____

Relation to You _____

Date of Birth _____

Social Security # _____

Policy # _____

Group # _____

Co-Payment \$ _____

Effective/Termination Dates _____ / _____

***AS A COURTESY TO YOU WE WILL BILL YOUR PRIMARY INSURANCE FOR YOUR VISIT. WE DO NOT BILL SECONDARY INSURANCE EXCEPT FOR OBSTETRIC CARE. MEDICAID CARDS MUST BE PRESENTED PRIOR TO VISIT OR WILL NOT BE ACCEPTED.**

Whom may we thank for referring you to our office?

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Your signature indicates the following:

Insurance:

It is my responsibility to be knowledgeable and fully aware of my insurance coverage. I also understand that I am ultimately responsible for the balance to pay for any and all services rendered in the event that my insurance company denies payment for such services. If I have insurance including Medicaid but do not have proof at time of service I may either reschedule for another day or I must pay for the visit the day of service.

Fees:

I also understand that there is a \$50 service charge that I will be billed for appointments not cancelled 24 hours prior to my appointment. If I do not have insurance at the time of services I will be responsible to pay for my appointment that day, unless prior arrangements have been made. A \$25 charge will be billed for all returned checks. **I understand that co-payments are due before I am seen for my appointment.** I will be charged a \$5.00 service fee plus the co-pay if I do not pay before I am seen. I also understand that any balances left unpaid after 60 days will be charged a finance charge of 1.5% interest per month or \$5.00 monthly billing fee which ever is more.

Collection Agency:

If it is necessary to send my account to an outside collection agency I will be charged and responsible for collection costs, court costs and attorney's fees that APRN Associates LLC and the collection agency may add to the account for services.

Outcome:

I understand that pregnancy can be a great experience and that APRN Associates cannot guarantee a perfect outcome.

Client Signature: _____ Date: _____