A. Terrel Williams, M.D. Denise E. Phillips, M.D.

INFORMATION UPDATE FORM

Even if it has not been a long time since your last visit, we find that many patients do have changes, which makes filing your insurance difficult.

We appreciate you taking a few minutes to complete this information form; it will be used to update your file. We must also have a current copy of your insurance card in your file.

Today's Date: _____

Patient Name: _____

Social Security Number: _____Date of Birth: _____

Address: _____ City: _____

State: _____ Zip Code: _____Home Telephone #: _____Cell #: _____

Email Address: _____

Employer: _____Work Telephone #: _____

Name of Spouse: _____Work Telephone #: _____

Primary Insurance: _____Secondary Insurance: _____

Name of Policyholder: _____

Please answer the following, if the name of the policyholder is not the same as the patient:

Policyholder's Social Security Number: _____

Date of Birth: _____Employer: _____

Patient's relationship to policyholder: _____

AUTHORIZATION

I do hereby authorize payment directly to Terrel Williams, M.D./Denise Phillips, M.D., when assignment is accepted, for the benefits under the terms of My Federal Program and/or Private Insurance.

I do hereby authorize release of any medical information necessary to process insurance claims.

I do hereby agree to accept personal responsibility for the payment of charges for services rendered. All accounts are due and payable at the time of the visit. (As a courtesy to the patient we will file insurance claims to the Federal and Private Insurance carriers with which we participate. Patients are responsible for all co-pays, deductibles and non-payments.)

I do hereby accept full financial responsibility for all items or services, which are determined by my health care service plan not to be covered or not medically necessary. (Refractions, e.g. checking glass prescriptions, are not covered under the Federal programs or under most private health plans. Payment for this procedure will be expected at date of service. Contact Lens Fittings and Contact Lenses are never filed with insurance companies and payments are expected at date of service.)

If the patient is a minor, I do authorize examination of the patient.

There will be charges of $25.00 for unpaid balances over 90 days old and $25.00 for returned checks.

I have read and understand the above. _____

Signature of Patient and/or Responsible Party