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

PLEASE PRINT AND FILL OUT COMPLETELY BOTH SIDES AND SIGN

Today's Date: _____

Patient Name: _____ Nickname: _____

Address: _____ City: _____

State: _____ Zip Code: _____Home Telephone #: _____

Date of Birth:_____Age: _____ Sex: _____

Social Security Number: _____

Employer:_____Work Telephone #: _____

Name of Spouse: _____Work Telephone #: _____

Email Address: _____

Insurance Information

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: _____

Whom may we thank for referring you to us / from where did you hear about our clinic?

_____

Reason for visit? _____

List any medications you are allergic to: _____

List all medications you are taking: _____

_____

Nearest relative not living with you: _____

Address: _____ Telephone #: _____

Whom may we contact in case of emergency? _____

Phone: _____

Is this a Worker's Compensation case?_____

Who is financially responsible for this bill?_____

Payment is expected when services are rendered

Today I will be using the following method of payment:

_____Cash _____Check _____Credit Card (We accept VISA and MC)

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.

The management for this facility is committed to providing a safe working environment for our employees. Violence of any type, like intimidation, harassment or threats, will not be tolerated and will result in immediate termination of the doctor/patient relationship.

I have read and understand the above. _____

Signature of Patient and/or Responsible Party