JENNIFER FONTIUS, MD
Family Medicine

NAME: ____ **DOB:** __________________
Marital status: __________________

ADDRESS:
Street: ____ Unit#: __________________
City: ______________________________________ State: ____________ Zip:______________

CONTACT INFORMATION:
Cell: ________________________________ Home: ______________________________
Work: _______________________________
Email (for our use only): ____

DO YOU GIVE US PERMISSION TO LEAVE MESSAGES , RESULTS ON VOICEMAIL? Y/N
If yes, which number? ______________________________
List anyone else we may give results to: ______________________Tel:_____________________

EMERGENCY CONTACT:
Name: ______________________________ Relationship: ________________________________
Tel number: ____

INSURANCE:
Primary: _______________________ Group#: ________________ ID#: ____________________
Guarantor: _______________________________________ DOB: _________________________

Secondary: ____________________ Group#: ________________ ID#: ____________________
Guarantor: _______________________________________ DOB: _________________________

HIPAA: By initialing, you acknowledge receipt of our Notice of Privacy Practices and Patient Rights. ______

OFFICE POLICIES & PROCEDURES: By initialing, you acknowledge receipt of our Office Policies & Procedures and agree to abide by them. ______

FINANCIAL AGREEMENT:
Co-pays are due at the time of service. As a courtesy to you, we will bill your insurance company directly if we are contracted with them. However, *you are responsible for paying any charges (co-pays, co-insurance, deductibles, and non-covered services) not paid by your insurance company.*

You are also responsible for verifying that Dr. Fontius is in network with your insurance company for your particular plan, as well as ensuring that we have your correct insurance and personal contact information at each visit.

Unpaid balances will be sent to collections after 90 days and there will be an additional collection fee of 35% added to the balance.

By signing below, you acknowledge and agree to these terms.

PATIENT/GUARANTOR NAME: ____

SIGNATURE: _____________________________________ **DATE:** __________________