



How did you hear about us? \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Street address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home: \_\_\_\_\_ Cell \_\_\_\_\_ Work# \_\_\_\_\_

Date Of Birth \_\_\_\_\_ SSN# \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Employer Name & Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employment Status: FT PT RET Student Unemployed Disabled

Email Address \_\_\_\_\_ Emergency Contact Name & # \_\_\_\_\_

**Primary Insurance** Company Name: \_\_\_\_\_

Subscriber Name (*if different than patient*) \_\_\_\_\_

Member/Insured ID # \_\_\_\_\_ Group # \_\_\_\_\_ Copay: \$ \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Relationship to patient: \_\_\_\_\_

**Secondary Insurance** Company Name \_\_\_\_\_

Subscriber Name (*if different than patient*) \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Relationship to patient \_\_\_\_\_

Member ID# \_\_\_\_\_ Group#: \_\_\_\_\_ Copay\$ \_\_\_\_\_

**Responsible party Information** (Adult patients may leave this section blank)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home#: \_\_\_\_\_ Cell#: \_\_\_\_\_ Work#: \_\_\_\_\_

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes to the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. All fees for professional services are due and payable at the time of treatment. If you have insurance, as a courtesy, we will process your forms. We require that you pay your estimated portion when services are rendered and any unpaid balance that the insurance does not pay for after forty-five days. After that time a collection fee may apply. The patient (parent or guardian) will be held liable for attorney's fees of 15% of the balance due if unpaid after 90 days. Please be advised that 24-hour notice is required to change/cancel an appointment. Last minute cancellations are subject to a broken appointment fee of \$50. Also, after two no shows a \$75 fee will be charged to the patient.

I acknowledge and agree that payment for services rendered is due at the time that such service is rendered and that payment arrangements must be made in accordance with the terms of the financial policy. I authorize payment of benefits to Dr. Paul E. Burk for services rendered under the terms of my insurance policy. I authorize Dr. Paul E. Burk to release any information or other information necessary to process insurance claims.

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_