Atlas Infectious Disease Practice PLLC

Atlas Infectious Disease Practice

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Board Certified, Infectious Diseases

INSURANCE INFORMATION # 1

Insurance Name: _____

Policy Number: _____ **Group #:** _____

Subscriber Name: _____

Relationship to Patient: _____ **DOB:** _____

Is today's visit the result of an accident? No: ____ Yes: ____ **Date of Accident:** _____

INSURANCE INFORMATION # 2

Insurance Name: _____

Policy Number: _____ **Group #:** _____

Subscriber Name: _____

Relationship to Patient: _____ **DOB:** _____

I hereby assign to ATLAS INFECTIOUS DISEASE PRACTICE, PLLC all payments for medical services rendered to me or my dependents listed above. I understand that I am responsible for any amount not covered by insurance. I also authorize release of medical information necessary to process any health insurance claim.

Patient/Insured Signature: _____ **Date:** _____

NO SHOW POLICY

I understand that in the event that I am unable to keep my scheduled appointment, I must provide 24 hours notice to ATLAS INFECTIOUS DISEASE PRACTICE, PLLC. **If I do not call to cancel my appointment and I fail to show up for the scheduled appointment, I will be charged a fee of $50.**

_____ I acknowledge that I have read and understand the above no show policy. Initials

Patient/Insured Signature: _____ **Date:** _____

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