



Atlas Infectious Disease Practice

JOSEPH H. ETIENNE, MD
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. Provide initials.

Patient/Insured Signature: _____ Date: _____