

Gill Family Medicine

Health & Wellness

2422 Danville Road, Suite E
Decatur, AL 35603
(256) 355-9040

Patient Information <i>(Please Print)</i>			
Name	(First)	(Middle)	(Last)
Address	City	State	Zip
Email Address			
Home Phone	Cell Phone	Social Security Number	Driver's License Number
Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Race	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed
Employer	Employer's Phone #		
Spouse's Name	Spouse's Employer	Spouse's Work #	
Emergency Contact	Relationship	Contact #	
Type of Insurance	Subscriber Name	Subscriber Date of Birth	
ID #	Group #	Subscriber Relation to Patient	
Insurance Carrier Address			(Phone Number)
Secondary Insurance	Subscriber Name	Subscriber Date of Birth	
ID #	Group #	Subscriber Relation to Patient	

Financial Responsibility <i>(Complete this section if someone other than the patient is responsible for payment on this account.)</i>			
Person Responsible for Account	(First)	(Middle)	(Last)
Address	City	State	Zip
Home Phone	Social Security Number	Relation to Patient	
Date of Birth	Spouse's Employer	Spouse's Work #	
Employer	Work Phone	Email Address	

AGREEMENT TO PAY

The Patient/Responsible Party agree(s) to pay in full all charges submitted by Gill Family Medicine during Patient's treatment, including treatment rendered during hospitalization, unless Gill Family Medicine is legally obligated to accept payment for those charges solely from a third party. The Patient/Responsible Party agree(s) to be fully financially responsible to Gill Family Medicine, even though there may be insurance or other third party coverage, or even though the charges may exceed the amount reimbursed by insurance unless Gill Family Medicine is contractually obligated to accept reimbursement solely from a third party. In the case of HMO's or other third parties requiring specific referral authorization prior to making payment, Patient acknowledges and agrees that any service rendered without the Patient supplying the referral authorization will be considered a self-referral, for which the Patient/Responsible Party will be solely responsible for payment. Patient/Responsible Party agree(s) that failure to make payment when due is the basis for legal action, and agree(s) to pay, in addition to all amounts due, collection agency fees (33.33%), and/or reasonable attorney's fees and court costs, and agree(s) that their obligations are joint and severable, permitting Gill Family Medicine to pursue either or both for payment.

Signature: _____ Date: _____