PATIENT INFORMATION and FINANCIAL RESPONSIBILITY

Our Family Physician is: *[ ] Dr. Cervantes [ ] Dr. LaSure* *(Select your primary doctor)*

PATIENT INFORMATION

Name _____ Date of Birth _____

Address _____ SSN _____-_____-_____

City _____ State _____ Zip _____ Home Phone _____

Employer Name and Address _____ Wireless (Cell) Phone _____

_____ Work Phone _____

Email Address: _____ Online Portal Access: [ ] Yes [ ] No

Preferred Method of Contact: [ ] Phone [ ] Email

RESPONSIBLE PARTY - [ ] Parent [ ] Guardian [ ] POA [ ] Protective Payee [ ] Conservatorship

Name _____ Date of Birth _____

Address _____ SSN _____-_____-_____

City _____ State _____ Zip _____ Home Phone _____

Employer Name and Address _____ Work Phone _____

_____ Wireless (Cell) Phone _____

SPOUSE

Name _____ Date of Birth _____

Work Phone _____ Wireless (Cell) Phone _____ SSN _____-_____-_____

Emergency Contact/Relationship _____ ***Phone*** _____

How did you hear about our clinic? _____

INSURANCE*********A copy of your insurance card is required.***
If your account will be ***Self Pay***, then a copy of your Driver's License is required.

Acceptance of **FINANCIAL RESPONSIBILITY** and **AUTHORIZATION TO TREAT:**
Please read and sign below:

I hereby authorize FP Associates, PC to release any information acquired in the course of an examination or treatment for insurance and consultation purposes only.

I hereby authorize payment directly to FP Associates, PC of the medical benefits, otherwise payable to me, for the medical services rendered.

I understand that I am financially responsible for the amount of my bill, which is not paid by my insurance. If I have no insurance coverage, I am fully responsible for the total amount of the bill.

I hereby authorize FP Associates, PC to treat my family.

I have read and agree to the above.

Signed (Guarantor / Spouse) _____ Date _____

FP Associates, PC . 1103 Galvin Road South, Suite G . Bellevue, Nebraska 68005 .
402-292-1072

7/05, Revised: 2/06, 7/07, 3/12, 8/12, 1/13, 9/13