PATIENT DATA: **Membership Start Date:____/____/_______**

Membership Stop Date:____/____/_______

Patient's Full Name:____

Address:______________________________ **City:**______________________ **State:**_________

Home Phone:______________________________ **Cellphone:**_____________________________

Social Security #_____/_____/_____

Employer(if applicable)___________________________ **Work phone #**___________________

Marital Status: S M W D Birthdate:____/____/____ Age:________ Sex: M / F

Spouse's Name(if applicable)____

REFERRAL SOURCE

Name____________________________________ **Phone#**_________________________________

Address__________________________________ **Misc**___________________________________

INSURANCE INFORMATION:

Primary Insurance:_______________________ **Secondary Ins.**_________________________

IN CASE OF EMERGENCY CONTACT INFORMATION:

Name:_______________________________________ **Relationship:**_______________________

Home Phone #_____________________________ **Cellphone#**_____________________________

AUTHORIZATION:

I authorize Hansa Medical Groupe, LLC to release any information obtained by all provided medical care, to other medical facilities, physicians, and/or insurance carriers as deemed necessary by Hansa Medical Groupe, LLC. This practice does not take responsibility for any further disclosures made by those parties. I also authorize my insurance company to make payment to Hansa Medical Groupe for services rendered and shall remain in effect until membership to the practice is terminated by either party.

POLICY & AGREEMENT:

With respect to membership to and medical services rendered by Hansa Medical Groupe physicians and staff, I agree to the following:

I understand that the membership to Hansa Medical Groupe is included in the charge for the annual comprehensive history & physical evaluation and is not involving billing for medical services rendered to my health insurance policy. Home visits provided by the practice are not the same as services at a physician's office, hospital, or emergency room.

All fees are to be paid according to the set schedule as stated, unless other arrangements have been made with the physician. It is my responsibility to provide insurance information to Hansa Medical Groupe, LLC at the time of initial services, so appropriate billing may be conducted. Otherwise payment is due in full at the time of service.

I HAVE READ AND ACCEPTED THE ABOVE POLICY AND AGREEMENT.

____

SIGNATURE

____

DATE

MEDICARE PAYMENT PERMISSION OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENTS

(REQUIRED SIGNATURE BY MEDICARE)

Name of Patient ____________________ Medicare Number (HICN) ____________________

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by Hansa Medical Groupe, LLC, including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services.

Secondary:

MediGap Carrier ____________________ MediGap Policy Number ____________________

I request that payment of authorized MediGap benefits be made either to me or on my behalf for any services furnished to me by Hansa Medical Groupe, LLC, including physician services. I authorize any holder of medical or other information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services.

Signature of Patient ____________________ Date ____________________