Alicia R. Carter, M.D.

Patient Last Name: _____ First: _____ MI: _____

DOB: _____ Age: ____Gender: (circle) M F Marital Status: (circle) S M W D SP

Street Address: _____ City: _____ State: _____ Zip: _____

Daytime Phone: _____ Home Phone: _____

Our practice finds e-mail to be highly efficient means of communication between staff and patients. Although we do our best to keep e-mail communications private from outside sources, we cannot guarantee 100% privacy. If you would like to use e-mail as a NON-Urgent communication option, please provide your signatures and e-mail address.

Signature: _____ E-mail Address: _____

Referring Physician: _____ Address/Phone: _____

Primary Physician: _____ Address/Phone: _____

Pharmacy Name: _____ Pharmacy Address/Cross Street: _____ Phone number: _____

Employer: _____ Employer Address: _____
Emergency Contact: _____ Relationship: _____
Emergency Contact Phone: _____

Guarantor (any person responsible for payment other than patient)
Name: _____ Relationship to patient: _____
Address: _____ Daytime phone: _____
DOB: _____ Gender: M F Employer or Group: _____

Is the reason for your visit the result of an automobile or work-related injury? **Yes or No** If YES, please inform the office staff, as we don't accept No-Fault.

AUTHORIZATION

I authorize the release of medical information pertaining to my history, services rendered, or treatment given to me or my dependents for purpose of review of this claim. I authorize payment of benefits to be made to the physician rendering the service. I will be held responsible for any costs which are not covered by my insurance carrier and will be directly billed for such costs.

Signature: _____Date: _____

FINANCIAL POLICY

All fees, including co-payments and co-insurance payments, are due at the time of service. Payment is accepted in the form of cash or credit card. Checks are accepted up to $100.00. There is a $50.00 charge for returned checks. Any unpaid balances are subject to a 30-day late payment charge and a monthly interest charge at the maximum rate allowed by law. All delinquent accounts will be reported to credit reporting agencies. Any attorney fees or collection fees that we incur in the process of collecting outstanding balances will be added to original balance.

24 HOUR CANCELLATION POLICY

In consideration to other patients and our practice, kindly give 24 business hours' notice if you are unable to keep your appointment (before 2:00 pm on Friday for Monday appointment or 2pm before a holiday). A fee will be charged for ANY REASON for any late cancellation. **$200 for initial visits and $100 for follow–up visits and $100 for physical therapy appointments.**

I have read and understand the above financial and cancellation policies.

Signature: _____Date: _____