ROBERT E. FORD, M.D.
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SARASOTA, FL 34239 (941) 925-9355

PATIENT INFORMATION AND TREATMENT CONSENT

PATIENTS NAME (PLEASE PRINT)	SS #	MARITAL STATUS S M W D S	SEX M F	BIRTH DATE	AGE
STREET ADDRESS (LOCAL)	CITY AND STATE	ZIP CODE	HOME PHONE #		
STREET ADDRESS (OUT OF TOWN)	CITY AND STATE	ZIP CODE	HOME PHONE #		
EMPLOYER (OR SCHOOL IF STUDENT)	OCCUPATION		BUSINESS PHONE #		
IF PATIENT IS A MINOR, PARENT / GUARDIAN NAME	PERSON TO NOTIFY IN CASE OF EMERGENCY		EMERGENCY PHONE #		

MAY WE LEAVE A DETAILED MESSAGE ON YOUR ANSWERING MACHINE? YES ___ NO ___

PRIMARY LANGUAGE SPOKEN BY PATIENT: _____

HOW WILL YOU BE PAYING FOR YOUR VISIT TODAY? ___cash ___check ___credit ___insurance

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY	POLICY #	GROUP #	EFFECTIVE DATE	CO-PAYMENT
POLICY HOLDER NAME	EMPLOYER	SS #	BIRTH DATE	DEDUCTIBLE

SECONDARY INSURANCE COMPANY	POLICY #	GROUP #	EFFECTIVE DATE	CO-PAYMENT
POLICY HOLDER NAME	EMPLOYER	SS #	BIRTH DATE	DEDUCTIBLE

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR CUSTOMER SERVICE DEPARTMENT. SHOULD IT BECOME NECESSARY TO INITIATE COLLECTION PROCEEDINGS THROUGH AN OUTSIDE COLLECTION AGENCY OR LITIGATION, THE UNDERSIGNED HEREBY AGGREES TO PAY ALL COSTS ASSOCIATED WITH SUCH COLLECTIONS, INCLUDING ATTONEY'S FEES AND ANY OTHER APPLICABLE COSTS.

TREATMENT CONSENT AND INSURANCE AUTHORIZATION / ASSIGNMENT

I consent to treatment and certify that no guarantee or assurance has been made as to the results which may be obtained. I authorize the health care providers of Suncoast Family Practice, (including but not limited to: medical physicians, nurse practitioners, and physician assistants), to treat my condition in the fashion they deem appropriate, necessary and proper. I acknowledge that the health care providers of Suncoast Family Practice, shall have no liability, whether direct or indirect, if I do not follow, or if I improperly utilize, the prescribed course of treatment or evaluation, including prescribed return visits, referrals, consultation, self care, etc..

For services beginning today, I authorize any holder of medical or other information about me to release to the Social Security Administration and health Care Financing Administration or its intermediaries or carriers, or to other billing agents of Suncoast Family Practice, and information needed for this or a retained Medicare claim. I permit a copy of this authorization to be used in place of their original and request payment of medical insurance benefits, either to myself or to the party who accepts assignment.

I request that MEDIGAP benefit payments be authorized and made payable on my behalf to Suncoast Family Practice, for any services furnished by Suncoast Family Practice. I authorize any holder of medical information about me to release to my insurance carrier any information needed to determine these benefits or the benefits payable for related services. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim, because my signing this authorization will cause Medicare payment information to cross over automatically.

SIGNATURE_____ **DATE**_____