William B. Cobb, M.D., FACS
Keith E. Matheny, M.D.
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Bradford A. Bader, M.D.
Kenny B. Carter, Jr., M.D.

THIS FORM NEEDS TO BE COMPLETED IN FULL

PATIENT INFORMATION **DATE: _____/_____/_____**

If your insurance program requires a referral, it is your responsibility to obtain this before your appointment time; otherwise we are required to reschedule this appointment. When registering, please present proof of insurance, Medicare and/or Medicaid and your Driver's License.

Patient Information

Full Legal Name: _____ Date of Birth: _____ Age: ____ Sex : ____

Address: _____ City: _____ State: _____ Zip Code: _____
(Mailing address)

Phone (home) _____ Work/Cell _____ Single Married Divorced Widowed

Driver's License # _____ Social Security # _____-_____-_____

Employer _____ Occupation _____

Insurance Information of Insured

Name of Insured _____ Date of Birth _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____ Phone _____

Social Security # _____/_____/_____

Employer _____ Work Phone _____ Occupation _____

Name of Insurance Company _____ Phone _____

Address (for claims) _____

City _____ State _____ Zip _____

Member ID # _____ Group # _____

Spouse/Guardian

Name _____ Date of Birth _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____ Phone _____

Employer _____ Work Phone _____

Social Security # _____/_____/_____

Please provide a telephone number we may leave a private message to remind you about appointments & results.

Private Telephone Number _____

Primary Physician _____ Phone _____

Referring Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

NAME OF SOMEONE TO CONTACT IN CASE OF AN EMERGENCY _____

RELATIONSHIP _____ HOME PHONE _____ WORK/CELL_____

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I AUTHORIZE WILLIAM COBB, M.D.; EWEN TSENG, M.D.; KEITH MATHENY, M.D.; BRADFORD BADER, M.D.; KENNY B. CARTER, JR., M.D.; TO RELEASE AND FURNISH ON A CONFIDENTIAL AND STRICT NEED TO KNOW BASIS ALL MEDICAL AND FINANCIAL DATA RELATED TO MY CARE THAT MAY BE NECESSARY NOW OR IN THE FUTURE TO FACILITATE PAYMENT BY THIRD PARTIES FOR SERVICES RENDERED BY PHYSICIAN, OR TO ASSIST WITH, AID IN, OR FACILITATE THE COLLECTION OF DATA FOR PURPORSES OF UTILIZATION REVIEW, QUALITY ASSURANCE, OR MEDICAL OUTCOMES EVALUATION PURPOSES. SUCH INFORMATION MAY BE RELEASED TO INSURANCE COMPANIES, HMO'S, PPO'S, MANAGED CARE ORGANIZATIONS, INDEMNITY PLANS, MEDICARE/MEDICAID OR OTHER GOVERNMENTAL OR THIRD PARTY PAYERS, OR ANY ORGANIZATIONS CONTRACTING WITH ANY OF THE ABOVE ENTITIES TO PERFORM SUCH FUNCTIONS. I ALSO GIVE MY AUTHORIZATION TO HAVE A COPY OF MY MEDICAL RECORDS DELIVERED TO MY PRIMARY CARE PHYSICIAN FOR MY MEDICAL CARE OR THE PAYMENT THEREOF.

PATIENT'S SIGNATURE _____

PATIENT'S RESPONSIBILITY

SIGNING OF THIS FORM IN NO WAY IMPLIES THAT YOUR VISITS WITH THIS OFFICE WILL BE COVERED BY YOUR INSURANCE COMPANY, WILLIAM COBB, M.D.; EWEN TSENG, M.D.; KEITH MATHENY, M.D.; BRADFORD BADER, M.D.; KENNY B. CARTER, JR., M.D.; AND THEIR EMPLOYEES CANNOT GUARANTEE ANY INFORMATION GIVEN TO US BY YOUR INSURANCE CARRIER REGARDING YOUR BENEFITS.

1. **IF YOU ARE NOT PART OF AN HMO, PPO, MEDICARE/MEDICAID, OR MANAGED CARE CHOICE PLAN THAT WE PARTICIPATE IN, YOU WILL BE RESPONSIBLE FOR YOUR BILL AT THE TIME OF SERVICE.**
2. **IF YOU ARE PART OF A PPO PLAN AND YOU HAVE A DEDUCTIBLE FOR SERVICES OTHER THAN YOUR REGULAR OFFICE COPAY, YOU WILL BE RESPONSIBLE FOR PAYMENT OF SAID DEDUCTIBLE.**
3. **IF YOU ARE PART OF A MANAGED CHOICE OR HMO PLAN, FAILURE TO OBTAIN A VALID REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN (PCP), MAY RESULT IN NO BENEFTIS BEING PAID. YOU WILL BE RESPONSIBLE FOR ANY NON-PAYMENT FROM YOUR INSURANCE CARRIER.**
4. **DUE TO CONTRACT LANGUAGE BETWEEN PHYSICIAN AND INSURANCE COMPANY, I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES DEEMED TO BE "NON-APPROVED" BY MY INSURANCE COMPANY BUT THAT I STILL MAY OWE THE PROVIDER FOR SERVICES RENDERED.**

PATIENT'S SIGNATURE _____

DATE _____

09.13.2013