John A. Stewart, M. D.

Account #: _____ **PATIENT INFORMATION** Date: _____

SSN: _____ Birthdate: _____ Sex: _____ Marital Status: _____

Last Name: _____First: _____ Middle: _____ Preferred Name: _____

Address: _____

City: _____State: _____ Zip: _____ Phone: (_____)_____ Cell: (_____)_____

Do we have your permission to leave a message on your answering machine at home or cell phone? Yes No
Do we have your permission to contact you via email? Yes No Email Address: _____

Primary Physician: _____Referring Physician: _____

Employer: _____ Phone: (_____)_____X-_____

Person Responsible for Account:_____

Address:_____

City: _____State: _____ Zip: _____ Phone: (_____)_____

Person to notify in case of emergency: _____Phone: (_____) _____

Insurance Company (Primary): _____

Policy Holder's Name: _____Birth date: _____ Relationship: _____

Employer: _____

Contract Number: _____Group Plan Number: _____

Insurance Company (Secondary): _____

Policy Holder's Name: _____ Birth date: _____ Relationship: _____

Employer: _____

Contract Number: _____Group Plan Number: _____

AGREEMENT TO PAY

In consideration of medical services rendered, the undersigned accepts all fees charged as lawful debt and agrees to pay John A. Stewart, M. D., P. C. insurance notwithstanding, for all said charges. Furthermore, undersigned agrees to pay the costs of collections including reasonable attorney's fees, and court cost if such be necessary, waiving now and forever the right of exemption allowed to the constitution and the laws of the State of Alabama or any other state. Undersigned further understands that John A. Stewart does not accept insurance assignment as a guarantee of full payment.

We would also like to make you aware that most insurance companies are now applying any procedures performed in a physician's office to your major medical deductible. This includes, but is not limited to, excisions, shaves, and destructions (cryosurgery). If you have not met your major medical deductible for this year with your insurance company, you will be billed for the amount your insurance company shows as patient responsibility.

Assignment of Insurance Benefits and Release of Information

My signature below authorizes my insurance company to mail payment of authorized benefits for any medical services rendered directly to John A. Stewart, M. D., P. C. Furthermore, my signature below authorizes John A. Stewart, M. D., P. C. to release my insurance company medical information regarding his treatment for the purpose of determining eligibility for and payment of charges for services rendered in connection with his care.

Health Insurance Portability and Accountability Act (HIPAA)

I consent to use or disclosure of my protected health information (PHI) by John A. Stewart, M. D., P. C. (the Company) for the purpose of diagnosing or providing treatment to me, obtaining payment for health care bills or to conduct health care operations.

SIGNATURE: _____ DATE: _____