Abbeville Internal Medicine

A Division of Abbeville County Memorial Hospital

IMPORTANT NOTICE

Due to HIPPA requirement, this form MUST be filled out completely
Please ask for help if you have questions about any field.
We will be UNABLE to file insurance for incomplete forms.

Patient Information

First Name ________ Middle Initial:____ Last Name:________ Name you wish to be called: ________

Social Security #: ________ Date of Birth: ________ Age: ________

Mailing Address: ________ City/State: ________ Zip Code: ________

Home Phone: ________ Cell Phone: ________ Email Address: ________

Gender: ________ Race: ________ Marital Status:________ Spouse Name: ________

Employment Status: Full Time Part Time Self Retired None Student Status:

Employer/School Name: ________ Work Phone #: ________

Employer Address: ________

Emergency Contact Information should not be someone living in the home with you

Emergency Contact: ________ Phone #: ________

Family Physician: ________ Pharmacy Name ________

HIPPA Authorization Access to Medical Record

I authorize the following people to have access to my protective health information or medical information:

Please list the names and the relationship to you: ________ ________ ________

INSURANCE INFORMATION

	Primary	Secondary	Tertiary
Subscriber(Legal Name:			
Telephone:			
Relation to patient:			
Date of Birth:			
Social Security Number:			
Employer:			
Address:			
City, State			
Zip Code			
Employer Phone #:			
Insurance Company:			
Subscriber ID #:			
Group #:			
Patient ID (If different)			
Insurance Telephone #..			

BENEFIT ASSIGNMENT AND RELEASE OF INFORMATION

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, certify that the insurance information listed above is correct and that all insurance benefits for services rendered are directly assigned to Abbeville Internal Medicine. I understand that I am finacially m financially responsible for all charges regardless of benefits. I hereby authorize the release of information necessary to secure payment of benefits. I authorize the use of this signature on all insurance claim submissions. Should this account be turned over to a collection agency for collection, I understand and agree that I will be obligated to pay all collection costs, including, but not limited to, reasonable attorney's fees.

Signature:________ Date: ________