Front Royal Family Practice

Patient's Name (Last, First, MI):__________________________________ Date of Birth:___________ Age:_____

Home #:_____________________ Cell #:______________________ Work #:______________________________

Physical Address:____

Mailing Address:____

Emergency Contact:____

Relationship to Patient:____________________________ Home #:________________ Cell #:________________

Primary Insurance Name:___________________ ID #:__________________ Patient is Subscriber: Y/N

Secondary Insurance Name:_________________ ID #:__________________ Patient is Subscriber: Y/N

I certify that all information reported above is correct including my insurance information. I authorize the release of any medical and financial information relating to services rendered be released to my insurance carrier(s) by Front Royal Family Practice to obtain payment. I further authorize payment of all medical insurance benefits for my services be made payable to Front Royal Family Practice.

I understand it is my responsibility to know my insurance benefits prior to seeking services and that I agree to render payment in which I am financially responsible. I understand that payment is due at time of service unless prior arrangements have been made with the billing department. I understand that Front Royal Family Practice will add a 35% collection fee along with interest for delinquent balances. I understand delinquent balances may result in discharge from the practice. A copy of this authorization may be used in place of the original in submitting claims for rendered services. This authorization can be revoked in writing by me and/or my insurance carrier.

I understand if I am a self-pay patient that payment is due at time of service and that I may receive additional bills from other entities (ex. Lab Company), which are separately payable from the services paid to Front Royal Family Practice.

I understand any returned checks will be subject to a service charge for which I am responsible. And I understand Front Royal Family Practice reserves the right to charge a fee for any scheduled visits that are:

1. **Missed without calling to cancel (No Show)**
2. **Arrive half past the appointment duration**
3. **Call to cancel less than 24 hours before appointment time**

My signature certifies agreement of the above policy and that Front Royal Family Practice has provided me a copy of the consent form.

Print Patient Name:_____________________________________ Account Number:________________

Signature of Patient/Guarantor/Legal Guardian:_________________________ Date:_______________