Charles P. Virden, M.D., F.A.C.S.

PATIENT INFORMATION

NAME OF PATIENT: _____ BIRTHDATE: _____
(last) (first) (middle)

MAILING ADDRESS: _____CITY: _____STATE: _____ZIP: _____

HOME PHONE:_____ CELL PHONE:_____ E-MAIL: _____

PREFERRED CONFIRMATION METHOD: □ TEXT □ EMAIL □ PHONE CALL

SOCIAL SECURITY #: _____ MARITAL STATUS: □ SINGLE □ MARRIED □ OTHER

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____ PHONE: _____

EMPLOYER: _____ OCCUPATION: _____ WORK PHONE: _____

HOW DID YOU HEAR ABOUT US?

☐ Our Website ☐ Drive By ☐ Radio ☐ Social Media ☐ Google/Web Search ☐ DR Office ☐ Word of Mouth
☐ Patient: _____ ☐ Other: _____ May we use your name when thanking them? ☐ YES ☐ NO

CANCELLATION POLICY

Please arrive 15 minutes prior to your scheduled appointment time. This will allow enough time to fill out and update any needed forms to begin your appointment as close to the scheduled start time. A late arrival may result in the need to reschedule your appointment so that we may best serve you as well as the other clients that day. We ask that you please make any changes to your appointment no less than 24 hours prior to your appointment to avoid any cancellation fees.

I understand that I am responsible for the payment of all services rendered, and I agree to follow the established credit policy of this office.

PATIENT SIGNATURE: _____ DATE: _____

HIPAA NOTICE OF PRIVACY POLICY

I, _____, understand Dr. Charles P. Virden's Notice of Privacy Policy (HIPAA) and hereby ☐ request **OR** ☐ decline a written copy of our Privacy Policy for my personal records.

PATIENT SIGNATURE: _____ DATE: _____

PAYMENT & USE OF INSURANCE COVERAGE

I understand that I am responsible for the payment of all services rendered. I understand that Dr. Charles P. Virden, and his Providers, are contracted with **some but not all** insurance carriers. I understand that if I choose to attempt payment using my insurance, I must provide accurate information and my claim is subject to approval by my insurance carrier. If my insurance claim is denied by my insurance company, I also agree to not hold Dr. Virden, or any of his staff, liable or responsible for the decision of the insurance company. I authorize payment of medical benefits to the named provider for services rendered AND I authorize the release of any medical information required for proper billing, payment, and authorization.

PATIENT SIGNATURE: _____ DATE: _____

****ONLY FILL OUT AT THE INSTRUCTION OF A STAFF MEMBER** The information listed above has been reviewed and is current:**

_____ _____ _____ _____ _____
Patient Initials & Date | Patient Initials & Date | Patient Initials & Date | Patient Initials & Date | Patient Initials & Date