AULTMAN
MEDICAL GROUP

PATIENT INFORMATION		FINANCIAL RESPONSIBILITY INFO	
Patient Name:		**Insurance Guarantor:**	
Address		**Address:**	
Address 2		**Address 2:**	
City, St, ZC		**City, St, ZC**	
Home Phone:		**Home Phone:**	
Work Phone:		**Work Phone:**	
Cell Phone:		**Cell Phone:**	
Birth Date:		**Birth Date:**	
Employer		**Employer:**	
Med Rec No			
Marital Status			
Patient E-Mail Address		**Guarantor E-Mail Address**	

Emergency Contact Name	
Emergency Contact Number	
Referred By:	
Other Physicians:	
PHARMACY NAME:	
Pharmacy Telephone:	

	PRIMARY INSURANCE	***SECONDARY INSURANCE***
Company Name		
Policy Holder Name		
Policy Holder Date of Birth		
Policy ID Number		
Group Number/Name		
Relationship to Policy Holder	Self Spouse Child Other	Self Spouse Child Other
Copay Amount		

****PLEASE READ SIGN WHERE INDICATED BELOW****

Patient Financial Responsibility and Assignment of Benefits:
I authorize Aultman Medical Group ("AMG") to bill my insurance or health plan, including Medicaid and/or Medicare, for the services that AMG provides to me and I hereby assign the payment of any medical benefits under such insurance or health plans to AMG. I further authorize AMG to release my medical or other information as necessary to obtain payment for services provided to me by AMG. I understand that I am responsible for any and all payment obligations arising out of the care, treatment and services provided to me by AMG, including deductibles, co-payments and any other patient responsibility under my insurance policy or for any service that is not covered by my insurance policy. I understand that co-payments, deductibles and other payments may be due on the date of my appointment or service and that AMG will collect such payment before services are provided to me. I understand that I have a right to review AMG's Patient Account/Financial Policy and that I may direct questions about this policy to AMG's Patient Accounts Department. I recognize that AMG's policies may change from time to time, without notice to me.

Consent to Treatment:
I hereby voluntarily consent to receive treatment and services at AMG. I give my permission to AMG, and to my physician (or my health care provider) to administer any service or treatment deemed necessary or advisable. I also specifically consent to medical procedures and tests determined necessary to assist in my diagnosis and treatment.

HIPAA A ACKNOWLEDGMENT: I hereby acknowledge that I received or was offered a copy of the Notice of Privacy Practices of Aultman Medical Group which sets forth the ways in which my health information may be used or disclosed by Aultman Medical Group and outlines my rights with respect to such information.

Patient or Patient Representative Signature		**Witness**	
Today's Date: Wednesday, August 24, 2016	**«PName»**		