*Referred by:*_____ *Date:* _____
Patient Name _____ Birthday: _____
Social Security #_____ Male_____ Female_____
Patient Address:_____
City, State, Zip:_____
Phone:_____ Email:_____

RESPONSIBLE PARTY

Name: _____ Phone:_____
Relationship to Patient: _____ Social Security # _____
Address:_____
City, State, Zip:_____

MINOR CHILD INFORMATION

Father: _____ Social Security # _____
Address:_____
City, State, Zip:_____
Home phone: _____ Work phone:_____ Email_____
Employer: _____ Occupation:_____
Work address: _____

Mother: _____ Social Security # _____
Address:_____
City, State, Zip:_____
Home phone: _____ Work phone:_____ Email_____
Employer: _____ Occupation:_____
Work address: _____

MEDICAL INFORMATION

Reason for visit: _____
Allergies: _____
Current Medical condition: _____
Current Medications: _____
Past Medical conditions: _____

INSURANCE INFORMATION

Your insurance is a method for you to receive reimbursement for fees you have paid to the physician for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowance or percentage based upon your contract with them, not with our office. It is your responsibility to pay by the end of each session. *(Exception: If you have United Healthcare or Blue Shield of California, you insurance will be billed first directly by our office. It is your responsibility to pay the deductible, co-payment or any other balance not paid by your insurance. Payment will be collected from you by the end of each session.).*

Please be aware that if are unable to keep a scheduled appointment, **48 hours advance notice** must be given or you will be charged for the time that was reserved for you.

PRIMARY INSURANCE

Company name:_____
Address:_____
City, State, Zip:_____Phone:_____
Insured's Name: _____
Relationship to Patient: _____ ID # _____ Group# _____

AUTHORIZATION AND RELEASE

I authorize Svetlana Libus, M.D. to release any information including diagnosis and the record of any treatment rendered to me or my child during the period of such care to third party payers.
I authorize and request my insurance company to pay directly to Dr. Libus insurance benefits otherwise payable to me.
I understand that my insurance carrier may pay less than actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents
This authorization will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original
I have read this information as well as information presented on the website: libusmd.com and understand it.

Patient/Responsible Party_____ Date _____