FILL OUT FORM COMPLETELY **Daryl S. Marx, MD**

WE DO NOT ACCEPT PERSONAL CHECKS

PAYMENT CAN BE MADE WITH CREDIT CARDS, CASH, CASHIERS CHECK & MONEY ORDER

Patient's Name (Last, First, Middle):	Social Sec. #:		Home Ph:
	Date of Birth:		Cell Ph:
Street Address:	Marital Status: S M W D	Age:	Ethnicity: Hispanic origin / Not Hispanic origin
City, State, Zip Code:	Race: White / Black/African American / Asian/Pacific Islander / American Indian/Alaska Native		

Patient's Employer	Employer's Address:	Employer's Ph:
Spouse or Guarantor's Name:	Social Security No.: / Date of Birth:	Home Ph: / Cell Ph:
Spouse or Guarantor's Employer:	Spouse or Guarantor's Employer's Address:	Employer's Ph:

Email Address:	Preferred Language:	
Emergency Contact (Other than Spouse): Name: / Relationship:	Emergency phone no:	Appointments reminders will be by mail, phone or email unless specific route declined (declined route_____). My preferred method is: MAIL PHONE EMAIL Preferred pharmacy:

Name of Insurance Company:	**Member Name:**	**Member ID:**	**Group/Policy #:**	**Effective Date:**
1. _____	_____	_____	_____	_____

Relationship of patient to the insured: _____ Member _____ Spouse _____ Child

2. _____	_____	_____	_____	_____

Relationship of patient to the insured: _____ Member _____ Spouse _____ Child

WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE TIME OF SERVICE.

Please do not assume that Dr. Daryl Marx is a provider for your insurance plan or that your insurance will be accepted and filed.

Payment for medical expenses will be made by: _____Cash _____Credit Card***PERSONAL CHECKS ARE NOT ACCEPTED***

ASSIGNMENT AND INSURANCE AUTHORIZATION

I authorize treatment for the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for myself and my family promptly upon receipt of the monthly statement unless credit or other arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of billing date. In the event legal action should become necessary to collect an unpaid balance that is due for medical services rendered to myself or my family, I agree to pay reasonable attorney's fees or other such costs as the Court determines proper. It is agreed that payments will not be delayed or withheld because of any insurance coverage or pending claims, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. A copy of this assignment is as valid as the original. Any charges accrued by an outside agency in attempt to collect a debt will fall on the responsibility of the patient/guarantor, according to office procedures. This also notifies you that Dr. Marx currently owns stock, along with other physicians, at Monroe Surgical Hospital.

I authorize the release of any medical or other information necessary for the use of treatment and to process insurance claims and also authorize payment of medical benefits to be paid by Dr. Daryl Marx.

I hereby acknowledge that I have read the above information, supplied information on this form that is true, and authorize all medical treatment.

DATE: _____ SIGNATURE: _____

~Notice: Do not sign this agreement before you have read and agree to the financial arrangements.~