INSURANCE STATUS

Please check all that apply to you, the patient

_____ Myself, or my child, only has insurance coverage with:

_____.

_____ There is no other health insurance coverage (private or state funded).

_____ Myself, or my child, is covered under **multiple** private and/or state health insurance companies. They are as follows:

_____

_____ I am covered under a **Workman's Compensation Claim.** I have supplied all information for billing purposes.

_____ I am covered under a **Personal Injury Claim** (to include motor vehicle accident). I have supplied all necessary information for billing purposes, **including Attorney Lien information.**

PRIVATE INSURANCE/UNINSURED PATIENTS, please initial
All information given is as true and accurate to the best of my knowledge. If any information is not correct and/or the insurance denies or retracts payments, I am responsible for any and all charges incurred. _____ (initials)

WORKMAN'S COMPENSATION/PERSONAL INJURY PATIENTS, please initial
All information given concerning my Workman's Compensation case and/or motor vehicle case are as accurate to the best of my knowledge. If for some reason the insurance denies payment, I am solely responsible. Also, if there is any change in Attorney status, I agree to contact South Forsyth Family Medicine and Pediatrics immediately. **If I do not, the contract is considered to be a breech of contract and I will be responsible for the amount in its entirety.** _____ (initials)

_____
PATIENT NAME DATE OF BIRTH

_____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN

_____
COMPLETE ADDRESS

_____
HOME PHONE WORK PHONE CELL PHONE

_____
STAFF SIGNATURE DATE