BILLING INFORMATION
Brian J. Williams, M.D., P.C.

PATIENT INFORMATION (Please print clearly)

PATIENT NAME: _____ DATE_____

DATE OF BIRTH: _____ SEX: Male /Female SSN: _____ MARITAL STATUS: Single/Married/Widowed

(Please check appropriate boxes)
LANGUAGE: English/Spanish/Other ETHNICITY: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Refuse to report
RACE: (please select one) ☐African American ☐White ☐Hispanic ☐American Indian ☐Native Hawaiian ☐Pacific Islander ☐Other

PHONE#: Home_____ Work: _____ Cell: _____

HOME ADDRESS: _____

City_____ State_____ Zip_____ *Email: _____

WHO CAN WE CONTACT IN CASE OF AN EMERGENCY? Name: _____

Phone#:_____ Relationship: _____
Do you give our office permission to discuss medical information with emergency contact? ☐Yes ☐No

DO YOU GIVE OUR OFFICE PERMISSION TO DISCUSS YOUR MEDICAL INFORMATION WITH FAMILY MEMBERS?
☐YES ☐NO IF YES, PLEASE PROVIDE THEIR NAMES AND PHONE NUMBERS BELOW.

NAME:_____RELATIONSHIP:_____PHONE #_____

NAME:_____RELATIONSHIP:_____PHONE #_____

WHO INTRODUCED YOU TO OUR OFFICE? _____

WHO IS YOUR FAMILY PHYSICIAN? (first and last name please)_____

B ILLING INFORMATION **(If Patient is over 18 the Patient is the responsible party)**
(Excluding insurance)
RESPONSIBLE PARTY (**Person/Guardian signing paperwork**):_____

DATE OF BIRTH:_____ RELATIONSHIP TO PATIENT: ☐Self ☐ Parent ☐ Spouse ☐ Legal Guardian

MAILING ADDRESS (if different from above):_____

City_____State_____Zip_____

INSURANCE INFORMATION DO YOU HAVE HEALTH INSURANCE? ☐ YES ☐ NO
IF YES, PLEASE PRESENT YOUR PHOTO ID WITH YOUR CARDS TO THE FRONT DESK TO TAKE A COPY. (PLEASE BE AWARE THAT IF WE DO NOT HAVE YOUR CURRENT INSURANCE INFORMATION WE WILL BE UNABLE TO BILL YOUR CLAIM)

PRIMARY INSURANCE: _____**IDENTIFICATION#**_____

Is Patient on Hospice ☐ YES ☐ NO

NAME OF INSURED: _____**DATE OF BIRTH:** _____

SECONDARY INSURANCE: _____**IDENTIFICATION#** _____

NAME OF INSURED: _____**DATE OF BIRTH:** _____

PLEASE SEE OTHER SIDE

I understand that I am financially responsible for all charges whether paid or not paid by my insurance. I am aware that if I do not provide current insurance information Dr. Williams' office will be unable to bill my claim.

ANY ACCOUNTS OVER THIRTY DAYS OLD WILL ACCRUE INTEREST OF 1.5% PER MONTH (18% PER YEAR) UNTIL THE ACCOUNT IS PAID IN FULL. In the event that full payment for charges incurred in my medical care is not made, I agree to pay all cost of collection, including 40% Collection Agency Commission and reasonable attorney's fees. I also agree to submit myself to the jurisdiction of the courts of Salt Lake County, Utah.

I understand that if a biopsy or pathology is necessary that unless otherwise specified it will be sent to and read by Dermpath Diagnostics Richfield Laboratory of Dermatology, a division of Ameripath. An administrative fee is added to each specimen. If insured, insurance will cover the fee.

I understand that in the event that I cannot make a scheduled appointment I must cancel 24 hours prior to that appointment time. Failure to do so will result in a $50.00 charge to my account (per incident).

I consent to medical treatment as provided by Brian J. Williams, M.D., P.C.

This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment will be considered as valid as an original.

✳ SIGNATURE:_____ DATE:_____
(Responsible Party)

I have received a copy of the Notice of Privacy Practices for Brian J. Williams, M.D., P.C.

✳ SIGNATURE:_____DATE:_____
(Responsible Party)

OFFICE USE ONLY

SIGNATURE: _____ DATE: _____
(Witness)

For Medicare & Medicaid Patients Only

According to the Centers for Medicare and Medicaid Services, a provider is to bill a Medicare beneficiary for his/her yearly deductible and coinsurance. In addition, a provider may bill Medicare beneficiaries for non-covered services and services that are considered to be not medically necessary as long as an Advanced Beneficiary Notice has been signed by the patient.

I agree that I am financially responsible for charges as outlined above. I am aware that if I do not provide current insurance information Dr. Williams' office will be unable to bill my claim.

I understand that in the event that I cannot make a scheduled appointment I must cancel 24 hours prior to that appointment time. Failure to do so will result in a $50.00 charge to my account (per incident). This fee <u>is not</u> billable to Medicare and Medicaid.

In the event that full payment for charges incurred in my medical care is not made, I agree to pay all cost of collection, Collection Agency Commission and reasonable attorney's fees. I also agree to submit myself to the jurisdiction of the courts of Salt Lake County, Utah.

I consent to medical treatment as provided by Brian J. Williams, M.D., P.C.

This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment will be considered as valid as an original.

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