

Kathryn A. Wagner, M.D.,P.A.

Date: _____

Name: _____ DOB: _____ Age: _____ Sex: _____

Marital Status: _____ Address: _____

City: _____ State: _____ Zip Code: _____ SS#: _____

Drivers License #: _____ Home Phone: _____ Cell Phone: _____

Other Contact /email#: _____

Employer: _____

Work Address: _____ City: _____ State: _____ Zip Code: _____

Work Phone #: _____ Occupation: _____ May we contact you at work? _____

Please give receptionist your driver's license and insurance card.

Emergency Contact: _____ Relationship: _____ Phone #: _____

Referring Physician: _____ Primary Care Physician: _____

Telephone #: _____ Telephone #: _____

Statement of Financial Responsibility

Please remember that insurance is considered a method of reimbursing the patient for fees to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay all deductibles, coinsurance, co-payments, or any other balance not paid by your insurance company. Read your insurance contract.**

I hereby assign all medical and/or surgical benefits, to include major benefits to which I may be entitled, including Medicare, Medicaid, private insurance, and other health plans to **Kathryn A. Wagner, MD, PA**. This assignment is to be considered as valid and original. This agreement includes insurance/health savings accounts, debit/credit cards processed via credit card machine, and bank checking accounts. **I understand that I am financially responsible for all charges whether or not paid by said insurance.** I hereby authorize and assign to release all information necessary to secure payment. *By paying with a credit/debit/health savings card or a bank check, I authorize Kathryn A. Wagner, MD, PA, to keep credit/debit/health savings account numbers, and bank account and routing numbers on file for the purpose of paying outstanding balances. I further understand and agree that an additional 40% will be added to my account in the event that it should be necessary for my account to be forwarded to a Collection Agency.*

I authorize disclosure of financial and medical records to the extent necessary to determine liability for payment and to obtain reimbursement.

Signature: _____ Date: _____

I have read and understand Dr. Wagner's New Patient Brochure

Signature _____ Date: _____

I have read and understand the Confidentiality Statement (HIPAA)

Signature: _____ Date: _____