Appointment Date: _____

Time: _____

BAY CLINIC, LLP
1750 Thompson Rd
Coos Bay, OR 97420
541-269-0333

Check-In Time: _____

PATIENT INFORMATION

Completion of this information in its entirety is required at time of visit/treatment

PATIENT'S NAME: _____ Social Security # _____
LAST FIRST MIDDLE

Sex: ☐ M ☐ F If Female, Maiden Name: _____ Birthdate: _____ Age: _____

Mailing Address: _____

Home Address (If Different): _____ City: _____ State: _____ Zip: _____

Primary Phone Number: _____ Occupation: _____

Employer: _____ Address: _____

Responsible Party Name: _____ Date of Birth: _____

Phone: _____ Social Security #: _____

Employer: _____ Phone: _____

For ID verification, please show driver's license to receptionist _____

Spouse Name: _____ Date of Birth: _____

Social Security #: _____ Employer: _____

NAME OF INSURANCE COMPANY: _____

NAME OF SUBSCRIBER: _____ Date of Birth: _____ Phone: _____

Subscriber's employer: _____ Phone: _____

A copy of your Insurance Card (front & back) is required to bill your insurance.

In case of emergency:

Relative to contact other than spouse or parent: _____ Phone: _____

Another person to contact other than relative: _____ Phone: _____

Who may we thank for referring you to this office? _____ Phone: _____

If your injury is job or MVA related, please ask receptionist for additional form.

Please sign and return to receptionist

I acknowledge that I am financially responsible for all charges, whether or not they are covered by insurance. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure the payment of benefits.

Signature: _____ Date: _____

BAY CLINIC, LLP
PHYSICIANS AND SURGEONS

Patient Name: _____

The following disclosures are made in compliance with the Federal Truth in Lending Law. The Bay Clinic, LLP will extend credit to a patient with the understanding that:

ALL CHARGES ARE DUE AND PAYABLE WITHIN 30 DAYS FROM DATE OF CLOSING STATEMENT.

NO REBILLING CHARGE will be imposed on accounts if the minimum scheduled payment is received EACH month before the statement date.

MINIMUM MONTHLY PAYMENT SCHEDULE

If your highest Balance is/was	$1.00-$30	$31-$100	$101-$150	$151-$200	$201-$250	$251-$300	$301-$400	Over $400
	Balance	$20	$25	$35	$40	$50	$58	17%

REBILLING CHARGE: A PERIODIC REBILLING CHARGE is imposed on account balances unpaid for more than 90 days after the first billing. A charge of $7.00 per month is imposed on such accounts.

If you are unable to meet our Monthly Payment Schedule, you must APPLY at the Patient Accounts Office and receive approval for a Budget Payment Plan. Budget Payment Plans are approved on a temporary basis according to eligibility and are reviewed at the end of a three month period.

REMEMBER! IF YOU HAVE ANY QUESTIONS, PLEASE ASK THEM TODAY. THANK YOU!

I have read and understand the above: _____
Signature of Responsible party

ASSIGNMENT OF INSURANCE PAYMENTS

I hereby authorize The Providers of Bay Clinic, LLP to furnish the insured's insurance company all information which said Insurance Company may request.

I hereby assign to The Providers of Bay Clinic, LLP all insurance proceeds to which I am entitled f or medical and/ or surgical expense relative to the services performed. I understand that this assignment does not relieve me from responsibility for charges not paid by my insurance company.

_____ _____ _____
RESPONSIBLE PARTY'S SIGNATURE PATIENT'S SIGNATURE DATE