

OLYMPUS CLINIC PATIENT INFORMATION SHEET

Today's Date ____/____/____

Patient's Name _____ **Date of Birth** ____/____/____

Street Address _____

City _____ **State** _____ **Zip** _____

Age ____ Sex ____ Marital Status Single ____ Married ____ Divorced ____ Widowed ____

Occupation _____

Employer _____ Employer Phone _____

Date of Appointment ____/____/____ Provider _____
(if known) (if known)

Responsible Party

Name _____

Street Address _____

City _____ **State** _____ **Zip** _____

Home Phone _____ **Business Phone** _____

Social Security Number _____

Employer _____

Name of Insurance Company _____ **Plan Name** _____

Address _____

Policy Number(s) _____ **Group No.** _____

I hereby authorize **Olympus Clinic** to furnish my designated insurance carrier all information concerning my present illness or injury. I also authorize benefits under this claim to be made payable directly to **Olympus Clinic**. I understand that I am responsible financially to the physician for charges not covered by this authorization.

SIGNED _____ DATE ____/____/____

OFFICE POLICY ON PAYMENT: All medical care is due and payable when completed, unless prior arrangements have been specifically made. We reserve the right to charge interest at 1 ½ % per month (18% annual) on balances 30 days and older. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all cost incurred in said unpaid balance, including a reasonable attorney's fee and collection fees.

Signature