**PATIENT INFORMATION**

Name: Soc. Sec. #:

 Last Name First Name M.I.

Address:

City: State: Zip:

Work Phone #: ( ) Cell Phone #: ( )

Email

Circle Sex: Male / Female / Other Age: Birth Date:

Business/ Employer: Type of Work:

Circle: Single/Married /Separated/Divorced/Widowed # Of Children:

Referred By: Primary Care Physician:

**PAYMENT POLICY**

1. **PAYMENT FOR ALL SERVICES AND SUPPLIES ARE DUE AT THE TIME OF EACH OFFICE VISIT**
2. Medicare co-payments will be billed to the patient after the Medicare explanation of benefits is received by this office, usually 60-90 days later
3. Dr. Conover and Dr. Palmer reserve the right to review special circumstances which may require a payment plan to be scheduled
4. Any balance over 30 days is subject to 1.5% per month service charge. Billing statements are mailed out each month.
5. Any dishonored check that is returned to us shall be subject to a $25.00 service charge.
6. Cost of Collections. The patient agrees to pay the costs, expense, attorney fees and other fees paid or incurred by Dr. Conover and Dr. Palmer should this matter be sent out for collection. This includes the costs of suit and other expenses incurred and reasonable attorney fees paid towards the collection whether suit is filed or not.

\*I HAVE READ, UNDERSTAND AND HAVE RECEIEVED A COPY OF DR. CONOVER AND DR. PALMER’S COLLECTION POLICY

\*PATIENT SIGNATURE: DATE: