TODAY'S DATE _____

NAME _____ BIRTHDAY _____ AGE _____

PLEASE USE FULL NAME (NO NICKNAMES)

ADDRESS _____

ZIP _____ HOME PHONE _____ CELL PHONE _____

E-MAIL ADDRESS (for future use) _____

CHOOSE ONE: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED

OCCUPATION _____ **HOW WERE YOU REFERRED HERE?** _____

BUSINESS NAME AND ADDRESS _____ PHONE _____

IF MARRIED, HUSBAND'S NAME _____ OCCUPATION _____

HIS BUSINESS NAME AND ADDRESS _____ PHONE _____

NAME AND ADDRESS OF CLOSEST RELATIVE _____
(except husband)

RELATIONSHIP TO YOU _____ PHONE _____

PRIMARY INSURANCE POLICY INFORMATION

Company _____ Policy # _____ Group # _____

Policy holder's name _____ DOB _____

SECONDARY INSURANCE POLICY INFORMATION **(Please print "NONE" If you are covered by only one policy)**

Company _____ Policy # _____ Group # _____

Policy holder's name _____ DOB _____

YOUR SOCIAL SECURITY # _____ DRIVER'S LICENSE # _____

i autorize Randy A. Fink, MD, LLC to charge the following credit card for any outstanding balance due to non-payment, insurance termination, denial, or inadequate coverage:

CHOOSE ONE: ☐ MASTERCARD ☐ VISA ☐ DISCOVER ☐ AMEX ☐ NOVUS EXP DATE _____

NAME ON CARD _____ ACCT # _____

GUARANTEE OF PAYMENT

I fully understand that I am directly responsible for payment to Randy A. Fink, MD, LLC for all medical and surgical services rendered to me. I also understand that all bills payable and become due at the time services are rendered, unless other arrengements have been made. I agree to pay for all collection costs, including reasonable attorney's fees and costs, in the event that it becomes necessary to file suit to effect payment.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the clinicians in this office to release any information acquired in the course of my examination or treatment to my insurance company for the purposes of processing any insurance claims.

ASSIGNMENT OF INSURANCE BENEFITS

If insurance claims are filed by this office on my behalf, I hereby authorize direct payment of any benefits to Randy A. Fink, MD, LLC for medical or surgical treatment received by me. In tis circumstance I understand that I am financially responsible for any charges not covered by insurance.

MALPRACTICE INSURANCE

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. Dr. Fink has decided not to carry malpractice insurance. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

_____

SIGNATURE

DO NOT WRITE IN THIS BOX

CURRENT AS OF: _____