STEVEN W. MELHORN, D.O.
MELHORN & MELHORN, D.O., INC.
1504 SANTA ROSA ROAD, SUITE 103
HENRICO, VA 23229-5109

FULL NAME: _____ SS#: _____

BIRTH DATE: _____ AGE: _____ SEX: M F MARITAL STATUS: SIN MAR DIV WID

STREET ADDRESS: _____ (H) PHONE: _____

CITY & STATE: _____ ZIP: _____ (W) PHONE: _____

EMPLOYER: _____ (C) PHONE: _____

JOB TITLE: _____ PRIMARY CARE PHYSICIAN: _____

SPOUSE NAME: _____ SPOUSE EMPLOYER: _____

SPOUSE PHONE NUMBER: _____ REFERRED BY: _____

BILL TO: SELF OR NAME & ADDRESS _____

_____

FOR EMERGENCY PURPOSE, NOTIFY _____

RELATIONSHIP _____ PHONE _____

DO YOU SMOKE? YES NO DRUG ALLERGIES: YES NO

PLEASE SPECIFY: _____

FREQUENTLY USED PHARMACY: _____ PHONE: _____

INSURANCE

PRIMARY INSURANCE COMPANY NAME: _____

SUBSCRIBER NAME: _____ DOB: _____

RELATIONSHIP TO INSURED: SELF _____ SPOUSE _____ CHILD _____ OTHER _____

POLICY #: _____ GROUP #: _____

SECONDARY INSURANCE COMPANY NAME: _____

SUBSCRIBER NAME: _____ DOB: _____

RELATIONSHIP TO INSURED: SELF _____ SPOUSE _____ CHILD _____ OTHER _____

POLICY #: _____ GROUP #: _____

IS THIS CONDITION RELATED TO AN ACCIDENT? YES NO DATE: _____

IS THIS CONDITION RELATED TO A WORK ACCIDENT: YES NO DATE: _____

IS THIS CONDITION RELATED TO A MOTOR VEHICLE ACCIDENT? YES NO DATE: _____

Please give your photo ID and insurance cards to the receptionist for copying

Turn page over and complete with signatures

MEDICAL SERVICES AGREEMENT

I, _____, certify that the information that I have provided is true and correct. I hereby authorize Steven W. Melhorn, D.O. to render medical services to me or my minor child named _____, and to release any information regarding my medical history, diagnosis and treatment of me, or my child, and if applicable, to my insurance company regarding my claim. I authorize payment of medical benefits to Melhorn & Melhorn, D.O., Inc, for services provided. I understand that I am financially responsible for all charges arising from the treatment of the above named or undersigned patient. If this account is referred to an attorney for collection, I agree to pay all attorney fees and court costs incurred.

Certain services performed in this office are considered by insurance companies to be physical therapy which may require pre-authorization. Although pre-authorization numbers are obtained, this is not a guarantee of coverage or payment until final review by your insurance company. Denied services will be billed to you accordingly. It is your responsibility to understand your insurance policy and eligible benefits and to obtain any necessary referral numbers. I understand that I will be financially responsible if I do not have a valid referral from my Primary Care Physician to receive specialty care services.

This document also serves as permission to obtain information from hospitals, emergency rooms, laboratory and x-ray departments, physician's offices, etc.

Signature: _____ Date_____

Patient Acknowledgement of receipt of Privacy Notice (HIPAA)
(copy provided at front desk and upon request)

Signature_____ Date _____

I authorize the release of my medical and/or financial information to ****OPTIONAL****

Name _____ Relationship_____

Name_____ Relationship_____

TO MY ATTORNEY OR INSURANCE COMPANY:

Please consider this letter as a claim or lien for the total of the above referenced bill on any proceeds recovered from my medical payments, insurance, and/or other source, in relation to the personal injury matter in which you are representing me.

Signature: _____ Date_____