HealthFirst
Family Care Center, inc.

Insurance

Primary Insurance_____

ID Number/Group Number_____ Effective Date_____

Policy Holder Name_____ Date of Birth_____ SS#:_____

Employer of Policy Holder_____ City_____

Secondary Insurance_____

ID Number_____

Group Number_____ Effective Date_____

Policy Holder Name_____ Date of Birth_____ SS#:_____

Employer of Policy Holder_____ City_____

Medicare

Name of Beneficiary_____

Health Insurance Claim #_____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Health First Family Care Center for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health First financing administration and its agents any information needed to determine these benefits or the benefits payable for related services. (This payment authorization is to be completed, signed by the beneficiary and retained in the files of the provider of service. It is valid for any service you provide for this beneficiary during his/her lifetime, unless revoked.

Medicaid

Name of Beneficiary_____

Health Insurance Claim #_____

Effective Date: _____

No Insurance

I have no insurance coverage. I understand that I will be expected to pay for the full cost of services provided at Health First Family Care Center at the time of services unless I have made other arrangements for payment.

I will apply for the health center's discount program. ❒Yes ❒No (Age 18 and above)

I will request a payment plan for services provided. ❒Yes ❒No

I will apply for Medicaid: ❒Yes ❒No

This is to certify that the above information is true and I hereby authorize Health First Family Care Center to verify any of the information I have provided. I understand that I am financially responsible for my co-pay and charges not covered by the insurance policy. I authorize Health First Family Care Center to release any information acquired in the course of my treatment or examination, to my insurance company for use in processing my claims. I authorize payment directly to Health First Family Care Center for surgical and medical benefits, otherwise payable to me for services described.

I understand the laboratory testing, x-ray services or other referred service that are ordered for LRGHealthcare to provide, will incur additional charges, and that I may be responsible for a portion of those costs. I agree to abide by the hospital's determination of cost for the services.

_____ _____

Signature Date