WELCOME TO OUR OFFICE

PLEASE PRINT CLEARLY **RUSSEL GLAUN, M.D.**

Name_____ **Date of Birth** _____

Address _____ **ZIP**_____

Phone Number# _____ _____ **Cell Phone#**_____

Northern Address _____ **ZIP**_____

Northern Phone # _____

Social Security # _____ _____ **Sex:** M F **Marital Status:** S M D W

Insurance/ Policy#_____

2nd Insurance/Policy#_____

Subscriber Name_____ **DOB**_____ **SS#**_____

Occupation _____ **Employer** _____**Bus Phone** _____

Name of spouse/emergency contact: _____

Relationship _____**Phone #** _____

Referred by: _____ **Medical Doctor** _____

If patient is a minor:

Name of Mother/Father/Legal Guardian:_____

Contact phone# _____ Social Security # _____

May we discuss your medical condition and account with any member of your household? Yes No

If yes, Name: _____**Relationship** _____

I hearby authorize treatment by Russel Glaun, M.D., or an associate. I also authorize release of any medical information necessary for processing insurance claims and allow photocopy of my signature for filing. I direct payment of medical benefits to the physician when advance payment in full has not been made. I understand that I am financially responsible for the fees for services rendered including collection charges and a finance charge of 1.5% per month on all overdue accounts.

I realize that it is my responsibility to verify with my insurance company that Russel Glaun, M.D. is contracted with my network. In addition, many insurance plans require a referral, authorization or use of an affiliated laboratory. If payment for my treatment is denied or reduced because (1) I did not have a referral or authorization, (2) an out-of-network laboratory is used for pathology services, or (3) I went out of my network for medical services, I will be personally responsible for all treatment costs. If payment has not been received from my insurance company within 60 days, for any reason, I understand that payment will be expected from me. All outstanding balances, co-pays, deductibles, and non-covered services are due at the time of visit. I have received a copy of the Notice of Privacy Practices for Russel Glaun, M.D.

Signature: _____ **Date:** _____