Ivette E. Diaz, MD., LLC
304 Federal Road,
Suite 201
Brookfield, CT 06804
Phone #: (203) 740-2593 Fax #: (203) 740-8250

PATIENT INFORMATION

Last Name: ________________ First Name: ______________________ M.I.: ________ Maiden Name: ________________
Street Address: ____ Apt: ___________ P.O. Box: _______________
City: ___________________ State: __________ Zip Code: _____________ Birth Date: ____________________
Social Security #: _______________ Marital Status: Single Married Divorced Widowed Other
Home Phone #: ____________________ Work Phone #: ____________________ Ext: ____ Cell Phone #: ______________
E-mail Address: _______________________________________ May we e-mail you? YES NO

PATIENT EMPLOYMENT

Employer Name: _______________________________________ Employer Phone #: _______________________________
Employer Address: ______________________________ City: _________________ State: _______ Zip Code: ___________
Occupation: ______________________ If Student: Full time Part time School: ______________________________

INSURANCE INFORMATION

Do you have Health Insurance YES NO
Primary Insurance Name: __________________ I.D. #: ____________________ Insured: ___________________________
Secondary Insurance: ____________________ I.D. #: ____________________ Insured: ___________________________

Spouse's Or Parents Information (If Patient is covered by Spouse's / Parent's Insurance)

Name: __________________________________ Birth Date: _______________ Social Security #: ____________________
Employer: _______________________________ Employer's Phone #: ____
Employer Address: ______________________________ City: _________________ State: _______ Zip Code: ___________
Is this visit injury related? YES NO ***If YES fill in all the information below:***
Injury related to: AUTO WORK OTHER: ____________
Insurance Carrier: ______________________________ Case #: ____________________ Policy#: ___________________
Insurance Address: ______________________________ Date of Accident: ____________________________________
Insurance Phone #: ______________________________ Contact Person: _____________________________________

EMERGENCY INFORMATION List nearest relative preferably not living with you

In case of an emergency, we may contact: _____________________________________ Phone #: _____________________
Relationship to Patient: ____ Other #: ___________________________

REFERRAL INFORMATION

Referred By: ______________________________

ASSIGMENT OF BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I hereby authorize my insurance to pay and hereby assigned directly to Ivette E. Diaz, LLC, all benefits, if any, otherwise payable to me for his/her services as described on the attached. I understand I am financially responsible for all charges incurred regardless if denied by my insurance carrier. I further acknowledge that any insurance benefits, when received and paid to Ivette E. Diaz, LLC, will be credited to my account, in accordance with above said assignment.

PAYMENT POLICIES

- For SELF-PAY Patients (Patients that have no insurance) are expected to pay in full at the time of the service for all office charges.
- Your co-payment/co-insurance MUST be paid in full at the time of the service.
- A $15.00 handling fee will be added for co-pays that are not paid the day of the service.
- A fee will be charged for completion of any form.
- There will be a $50 fee for returned checks and for no show.
- There will be a $50 collection fee if the account is forwarded to a collections agency, in addition to any finance charges that may be applied by the collection agency/legal fees.

I understand and agree to comply with all the policies of Ivette E. Diaz, M.D., LLC.

____ ______________________________

Authorized Signature of Patient and/or Subscriber Date of Signature