AVA HEALTH LLC PATIENT INFORMATION

Patient Name: First _____ **Middle Initial** _____ **Last** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Date of Birth: _____ **Age:** _____ **Sex:** _____ **Marital Status:** _____ **Social Security #** _____

Phone #: _____ **Cell #:** _____ **Work #:** _____

Email Address: _____

Employer: _____ **Employer's Address:** _____

Emergency Contact: _____ **Relationship to Patient:** _____

Phone #: _____ **Cell #:** _____ **Work #:** _____

Referring Provider's Name: _____ **Phone #:** _____

Responsible Party Information

Patient Name: First _____ **Middle Initial** _____ **Last** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Date of Birth: _____ **Age:** _____ **Sex:** _____ **Marital Status:** _____ **Social Security #** _____

Relationship to Patient: _____ **Home Phone #:** _____ **Work Phone:** _____

Employer: _____ **Employer's Address:** _____

Insurance Information

Are you covered by health insurance? _____ **If no, please make arrangements with our business office.**

Primary Insurance: _____ **Policy #:** _____ **Group #:** _____

Policy Holder Name: _____ **Policy Holder Date of Birth:** _____

Social Security Number: _____ **Copay:** _____

Secondary Insurance: _____ **Policy #:** _____ **Group #:** _____

Policy Holder Name: _____ **Policy Holder Date of Birth:** _____

Social Security Number: _____ **Copay:** _____

Consent for Payment

I hereby authorize payment of medical benefits billed to my insurance to Ava Health LLC. I have listed all health insurance plans from which I may receive benefits. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I agree to pay all co-payments, coinsurance, and deductibles at the time services are rendered. I also accept responsibility for fees that exceed the payment made by my insurance, if Ava Health LLC does not participate with my insurance. I hereby authorize Ava Health LLC to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and healthcare operations. There will be a $30.00 charge for all returned checks. I understand that while this consent is voluntary, if I refuse to sign this consent, Ava Health LLC can refuse to treat me. I understand this authorization can only be revoked in writing. If I revoke my consent, such revocation will not affect any actions Ava Health LLC took before receiving my revocation. I understand that in the event any unpaid balance is placed for collections with any third party collection agency a fee of 50% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, late fees, and any other fees so stated elsewhere. The authorized fee of 50% and the additional costs and charges listed above represent the actual costs incurred by Ava Health LLC to collect amounts owed under this agreement and a corresponding decrease in expected revenue resulting from the signer's failure to pay as specified in this agreement.

Signature of Patient or Patient's Representative: _____ **Date:** _____

Printed Name of Patient: _____ **Relationship of Representative to Patient:** _____