

\*\*\*PLEASE NOTE: Patients with HMO policies must have a referral from their primary care doctor. The referral must include the physicians ID Number and a prior authorization #.

Patient Demographic Information (PLEASE PRINT)

Date Home Phone ( ) Cell Phone ( )

PATIENT INFORMATION

Name Last Name First Name Middle Initial Soc. Sec.#

Address E-mail

City State Zip

Sex M F Age Birthdate Married Widower Single Minor Separated Divorced Partnered for years

Ethnicity: Caucasian Black Hispanic Asian or Pacific Islander Other

Patient Employer/School Occupation

Employer/School Address Employ./Sch. Phone( )

Emergency Contact Name Relationship Phone ( )

PRIMARY INSURANCE

Person Responsible for Account Last Name First Name Middle Initial

Relation to Patient Birthdate

Address Phone ( )

City State Zip E-mail

Person Responsible Employed by Occupation

Business Address Business Phone( )

Insurance Company Insur. Phone ( )

Contract # Group # Subscriber #

Names of other dependents covered under this plan

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Y N

Subscriber Name Last Name First Name Middle Initial

Relation to Patient Birthdate

Address (if different from patient's) Phone ( )

City State Zip E-mail

Subscriber Employed by Occupation

Business Address Business Phone( )

Insurance Company Insur. Phone ( )

Contract # Group # Subscriber #

Names of other dependents covered under this plan

ASSIGNMENT, RELEASE, and POLICIES

I certify that I, and/or my dependent(s), have insurance coverage with the above named insurance company(ies) and assign directly to Manuel E. Garcia, MD and/or Graham Kelly, DO all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I understand that there is a \$25.00 return check fee. I understand that if I NO-SHOW or fail to cancel my appointment 48 hours prior to my scheduled appointment, then MesoHealth, PC and VeinsPlus has the right to charge me a \$25.00 fee and/or deduct a treatment off of my purchased treatment package. I also understand that ALL SALES ARE FINAL on all products/hosiery and that no refunds or exchanges may be made. I also understand that there are NO REFUNDS on any type of treatment session or package purchase once the purchase has been made.

The above-named doctors may use my health care information and may disclose such information to the above named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. \*\*\*I understand that the below signed name is financially responsible for all charges and that full payment or insurance co-payment (which ever is applicable) is due at time of service.

Signature of Patient, Parent, Guardian, or Personal Representative Date

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient