# Stacy L. Siegel, M.D.

## Patient Information

**Name:** Last ____________________________ First _________________________ MI _________

**Address:** ___________________________________________________________________________

**City:** __________________________________ **State:** ____________ **Zip:** ___________________

**Phone:** C) _______________________ H) ____________________ W) _____________________

**Email Address:** ______________________________________________

**Date of Birth:** ______________________ **Male** _____ **Female** _____ **Marital Status:** _________

**Primary Physician:** _____________________________ **Who referred you?** __________________

**Circle all that apply:** If Employed: Full Time Part Time Self Employed Not Employed

Student Retired Active Military Duty Other

**Employer:** __________________________________________ **Phone:** ______________________

**Emergency Contact Person:** __________________________________________________________

Relationship: _____________________________ Phone: ____________________________

**PLEASE PROVIDE A COPY OF YOUR INSURANCE CARDS AND DRIVER'S LICENSE**

Although we do not file insurance, for purposes of prior authorization of medication it is important for us to have your most current information on file. Please notify us of any changes.

***APPOINTMENTS ARE CONTRACTED TIME. THE FULL FEE WILL BE CHARGED FOR APPOINTMENTS WHICH ARE NOT CANCELED 24 HOURS IN ADVANCE.*** _________ *(Initial)*

Agreement to Pay

In consideration of medical services rendered, the undersigned accepts all fees charged as lawful debt and agrees to pay Stacy L. Siegel, MD, LLC insurance not withstanding, for all said charges. Furthermore, undersigned agrees to pay the costs of collection including reasonable attorney's fees and court costs if such be necessary, waiving now and forever the right of exemption allowed to the constitution and laws of the State of Alabama or any other state. Undersigned further understands that Stacy L. Siegel, MD, LLC does not accept insurance payments as a guarantee of full payment.

Assignment of Insurance Benefits and Release of Information

My signature below authorizes my insurance company to mail payment of authorized benefits for any medical services rendered directly to Stacy L. Siegel, MD, LLC if applicable. Furthermore, my signature below authorizes Stacy L. Siegel, MD, LLC to release to my insurance company medical information regarding my treatment for the purposes of determining eligibility for and payment of charges for services rendered in connection with my care or for purposes of prior authorization of my medication.

Health Insurance Portability and Accountability Act (HIPPA)

I consent to the use or disclosure of my protected health information (PHI) by Stacy L. Siegel, MD, LLC (the Company) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations.

I have received a copy of the Company's Notice of Privacy Practices for review. The notice describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations of the Company.

**Signature:** ___________________________________________ **Date:** ___________________