Patient Information

First Name	Last Name	DOB	Age	Phone
Home Address		City	State	Zip Code
Social Security	M F Email	Spouse or Parent		Phone
Employer Occupation	Address			Phone

Billing and Insurance Information

PRIMARY				
Insurance Company Name		ID or Policy Number		Group/Code
Insurance Company Address		Policyholder's Social Security		Effective Date
Policyholder's Name	DOB	Phone	Relationship to Patient	
Policyholder's Address		City	State	Zip Code
SECONDARY				
Insurance Company Name		ID or Policy Number		Group/Code
Insurance Company Address		Policyholder's Social Security		Effective Date
Policyholder's Name	DOB	Phone	Relationship to Patient	
Policyholder's Address		City	State	Zip Code
SEND BILL TO				
First Name	Last Name	Phone	Relationship to Patient	
Address		City	State	Zip Code

Billing Policy and Patient Authorization

Payment is required at the time services are rendered and is the responsibility of the patient, parent, or guardian. Unless other arrangements are made, any unpaid balances are due within 30 days of receipt of the invoice. Payment is accepted in the form of cash, check, or money order. Accounts with balances open for more than 90 days may be charged interest on the unpaid balance.

I, the patient named above, hereby authorize DLS Medical Service, Inc. to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company, as referenced above, be made directly to the above-named provider.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing-agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original.

I authorize the provider or designated representative to contact me by telephone about appointments, billing, and medical care. As the patient or parent or guardian, I agree to the above terms and conditions.

Print Name	**Signature of Patient (Guardian or Parent)**	**Date**

Consent to Testing

I, the patient, hereby authorize DLS Medical Services, Inc. to perform all tests as may be prescribed by my physician. I understand that my attending physician monitors these tests and that DLS Medical Services, Inc. is not liable for any acts of omission when following the instructions of attending physician, who is neither an employee or an agent of DLS Medical Services, Inc. I agree to cooperate with my physician orders to the fullest possible extend to achieve the best possible results from diagnostic tests rendered by DLS Medical Services, Inc.

I attest that I did not have similar services performed at another physician's office or at any other medical facility.

Use and Disclosure of Personal Health Information Agreement

This disclosure contains information regarding the privacy of your personal healthcare information. Please read it carefully before signing. DLS Medical Services, Inc. will not condition treatment by your failure to sign this disclosure.

By signing this disclosure, I acknowledge that DLS Medical Services, Inc. may use or disclose my medical information for the purpose of my treatment or obtaining payment for services rendered.

Further, by signing this document I acknowledge that I have been provided a copy of and have read the Notice of Privacy Practices containing a complete description of my rights, and the permitted uses and disclosure, under HIPAA

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to Protected Health Information.

You may complain to us if you believe that your privacy rights have been violated by us.

Please list daytime telephone number(s) at which you prefer to be reached: ______________________________

The Federal Government now restricts medical facilities from discussing your health information and condition with other family members or person unless you specifically give your written permission.

By my signature below, I grant DLS Medical Services, Inc. permission to discuss my protected medical information with the following individuals:

First Name	Last Name	Phone	Relationship to Patient
First Name	Last Name	Phone	Relationship to Patient

DLS Medical Services, Inc. reserves the right to change the terms of this notice at any time.

Print Name	**Signature of Patient (Guardian or Parent)**	**Date**