Date: ______________________

(Please Print)

Name (Last)	(First)	(MI)	Marital Status S M W D	Date of Birth	Age
Home Address		City, State, Zip		Home Phone ( ) -	
Email Address		SS# / Maiden Name		Cell Phone ( ) -	
Employer of Patient/Responsible Party				Work Phone ( ) -	
Emergency Contact Name		Relationship to Patient		Emergency Contact Phone ( ) -	
Pharmacy	Pharmacy Phone ( ) -	Primary Care Physician		PCP Phone ( ) -	

Consent to Communicate:

I hereby give Scherbel Clinic LLC my permission to contact me or leave messages on the following (circle all that apply):

Home Cell

I hereby give Scherbel Clinic LLC my permission to release any or all of my health information to the following person(s). I will not hold Scherbel Clinic LLC liable for any information released.

Name of Person to Release Information to (Please Print)	Relationship to Patient	Phone Number ( ) -
Name of Person to Release Information to (Please Print)	Relationship to Patient	Phone Number ( ) -
Name of Person to Release Information to (Please Print)	Relationship to Patient	Phone Number ( ) -

Signature of Patient ______________________ Date ______________________

Insurance Informaiton

Primary Insurance Name		Secondary Insurance Name	
ID Number		ID Number	
Group Number	Effective Date	Group Number	Effective Date
Subscriber Name	Relationship to Patient	Subscriber Name	Relationship to Patient
Subscriber DOB	Subscriber SS#	Subscriber DOB	Subscriber SS#

Financial Policy

It is the responsibility of the patient to bring your insurance card to each visit, know your coverage, and obtain a referral/authorization if necessary. If a referral/authorization is necessary, but not obtained the patient will assume all financial responsibility. Full payment is due at each visit unless enrolled in a health care plan in which Scherbel Clinic LLC is also a participant. The following are accepted forms of payment: Visa, MasterCard, Discover, American Express, checks, and cash. All payments are to be made prior to your scheduled visit. Scherbel Clinic LLC is considered a specialist and your insurance may require copays for each visit. If a patient is to pay in excess of their balance, no credits will be issued until all claims have been adjudicated. Please remember, insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. If your account is delinquent and transfered to collection agency you will be responsibile for all fees associated in their collections process.

Signature of Patient ______________________ Date ______________________

Subsequent Year Update

I have reviewed the above and my information has remained the same

Signature of Patient ______________________ Date ______________________

Signature of Patient ______________________ Date ______________________