Charisse Litchman, MD

PERSONAL INFORMATION

Patient Name:_____
Male__ Female__ Date:_____
Birthdate:_____
Age:_____ SS#:_____
Single__ Married__ Other__
Spouse Name:_____
Address:_____
Home Phone:_____
Work Phone:_____
Cell Phone:_____
Occupation:_____Employer:_____
Emergency Contact:_____
Primary Care Physician:_____
Referred By:_____
Pharmacy Name:_____Location:_____

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third payors and/or other health practitioners.

I authorize and request that my insurance company pay directly to the doctor's group insurance benefits otherwise payable to me.

I understand that my indemnity insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my or my dependent's behalf.

I understand that my managed care company may require prior authorization or a primary care referral for treatment in the office. If I do

not obtain the required authorization or referral, I agree to be responsible for payment of any services rendered on my or my dependent's behalf.

We reserve the right to charge you directly for any appointments not cancelled without 24 hours notice, regardless of the insurance type.

We participate with Medicare, Anthem, Aetna and Empire PPO. Please present your insurance cards, flexible spending cards, and driver's license at the front desk before your appointment.

Signature_____Date:_____