Mooresville PPM, LLC

Outpatient Information

PATIENT INFORMATION	Account #:	Medical Record #:	Date:
Patient Name:		Referring Doctor:	
Billing Address:	City:	State:	Zip:
Physical Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	Other:
How did you hear about us?		Employer/School: (Address/Phone/Fax)	
Social Security #:	Date of Birth:	Age:	Marital Status:	Sex:
Emergency Contact:	Relationship:	Home Phone:	Cell Phone:
Next of Kin:	Relationship:	Home Phone:	Cell Phone:
Email (responsible party if minor/child):			
Responsible Party:	Relationship:	DOB:	SS#:
Responsible Party Address:			
City:	State:	Zip:	Home Phone:	Cell Phone:

INSURANCE INFORMATION			
Primary Insurance:	Employer:	Secondary Insurance:	Employer:
Insurance ID#:	Group #:	Insurance ID#:	Group#:
Insured Name:		Insured Name:	
Address:		Address:	
City:	State:	Zip:	City:	State:	Zip:
Insured DOB:	Insured SS#:	Insured DOB:	Insured SS#:

Financial Responsibility and Assignment of Insurance Benefits:

I guarantee payment to Mooresville PPM, LLC and its affiliates (Mooresville PPM, LLC) of all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment for surgical and medical benefits, which would otherwise be payable to me, to Mooresville PPM, LLC for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVII and/or XIX of the Social Security Act is correct.

Signature of Patient or Authorized Person: _____ ***Date/Time:*** _____

Insured Party or Financial Guarantor (if different from above: _____ ***Date/Time:*** _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)