Submit by Email

Last	First		Middle Initial
Street			
Zip	City		State
Work Phone:		Other Phone:	
Cell Phone:		E-mail:	
Date of Birth:	Gender: (circle) Male Female	Social Security Number:	
Occupation:		Marital Status:	

Referred by:	Last	First	Practice Address
Primary:	Last	First	Practice Address
Pharmacy:	Name	Location	Phone Number:

In Case of Emergency, Notify:	
Spouse/Partner's Name:	Phone:

Primary Insurance:		
Primary Insurance Address:		
Certificate or Policy #:	Group #	
Name of Policy Holder	Policy Holder DOB:	Relationship to Patient:
Policy Holder Employer:	Policy Holder DOB:	
Secondary Insurance:		
Secondary Insurance Address:		
Certificate or Policy #:		
Name of Policy Holder	Policy Holder DOB:	Relationship to Patient:

IF PATIENT IS A MINOR:

Mother's Name:	DOB:	SS#
Home Address:		Home Phone:
Occupation:	Employer:	Work Phone:
Father's Name:	DOB:	SS#
Home Address:		Home Phone:
Occupation:	Employer:	Work Phone:
Responsible Party For Payment: (please circle) Self, Mother, Father, Other		

INSURANCE: Please present current insurance information at the time of service.

CO-PAYMENTS: Co-payments are due at the time of service.

FINANCIAL ARRANGEMENTS: We understand that there may be circumstances in which you will want to make payment arrangements with our business office. Please contact Lori at 952-933-7700.

REFERRALS: If your insurance requires a referral, please obtain this referral prior to receiving care at Platinum Health; contact your primary physician or health plan to ensure your eligibility for maximum coverage by your plan. Information regarding referrals may be included on your identification card. Please remember that you are ultimately responsible for any balance that your insurance plan does not cover. We cannot guarantee the amounts of coverage offered by your insurance carrier, as each policy is different.

CANCELLATION POLICY – If you are unable to keep this appointment, a notice of 48 hours is required or a cancellation charge may apply and a deposit may be required to reschedule.

CREDIT POLICY AND PATIENT RESPONSIBILITY: It is your responsibility to seek coverage amounts and limits of liability on your insurance policy. It is your responsibility to know your insurance coverage. In the event your account becomes past due and is referred to an outside agency, you will be responsible for the collection costs along with any reasonable attorney fees.

FINANCE CHARGES of 1.5% per month, 18% per year, may be imposed on any balance over 90 days old. We would be happy to assist you in any way we can. Should you encounter any difficulties, please notify us as soon as possible to avoid any misunderstanding regarding your account.

To the best of my knowledge, I have completed the patient portion of this form, and I have read and understand my financial obligation and patient responsibility.

Signature of Insured_____ Date _____

Responsible Party (if minor) _____ Date _____

PAYMENT AUTHORIZATION/RELEASE OF RECORDS

I AUTHORIZE DIRECT PAYMENT FROM MY INSURANCE COMPANY TO PLATINUM HEALTH

I AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS AS NECESSARY TO MY INSURANCE COMPANY OR ANOTHER PHYSICIAN OR ANOTHER PARTY OF MY DESIGNATION FROM PLATINUM HEALTH, LLC.

Date _____ Signature of Insured _____ _____

Responsible Party (if minor)_____ _____

A signature must be on file in order to release your medical records to an insurance company or physician.
Per state law, this authorization automatically expires in 12 months, at which point we may find it necessary to have you complete another form.

If there are no changes, we can renew the existing form on an annual basis by having you re-sign below.

Date _____ Signature of Insured _____ _____

Responsible Party (if minor)_____ _____

Date _____ Signature of Insured _____ _____

Responsible Party (if minor)_____ _____

Date _____ Signature of Insured _____ _____

Responsible Party (if minor)_____ _____

Date _____ Signature of Insured _____ _____

Responsible Party (if minor)_____ _____