Tracy Hoos, DO
Jennifer Denton, APRN

Hoos Pediatrics
904 W Okmulgee
Muskogee 74401
918-910-7991

PATIENT INFORMATION (PLEASE PRINT & Fill Out Completely)

Date: _____

Patient's Name: First _____ Middle_____ Last _____

Preferred Name: _____ Date of Birth: _____ Age : _____ Sex: M or F

Patient's Address: _____

City, State & Zip: _____

INSURANCE INFORMATION

Name of Insured: _____

Name of Insurance Company: _____ Phone (_____)_____

I.D. Number: _____ Group Number: _____

I certify that I will be financially responsible for all medical expenses for the above patient in the event they should lose coverage of insurance during the course of treatment. **Sign:** _____

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PLEASE READ: Payment is required ***in full*** at the time of each visit. The patient, their parent, or their guardian are responsible for all fees, regardless of Insurance coverage. We will file insurance only as a courtesy, but ultimately our patients are responsible for all outstanding balances regardless of coverage.

AUTHORIZATION:
I understand that I will be charged (not my insurance) for canceled appointments unless I give 24 hours' notice.
All of the office policies have been provided to me and I understand all policies. I agree to all policies that have been provided to me in writing.

RELEASE OF INFORMATION:
I authorize the release of any medical information necessary to process insurance claims.
INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize and request payment of medical benefits directly to Hoos Pediatrics .

I CERTIFY THAT I AM THE RESPONSIBLE PARTY FOR THE PATIENT LISTED ABOVE AND THAT I HAVE THE AUTHORITY TO AGREE TO and SIGN ON BEHALF OF THE PATIENT FOR ALL SERVICES RENDERED. I, ALSO, CERTIFY THAT I AM THE FINANCIALLY RESPONSIBLE PARTY FOR THE PATIENT LISTED ABOVE and THAT I HAVE THE AUTHORITY TO AGREE TO ALL PRACTICE POLICIES AND FINANCIAL POLICIES.

Printed Name _____ **Relationship** _____

Signature_____ **Date**_____