

FAY M. AZAD, M.D.
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APPLICATION FOR TREATMENT

Patient Information

Patient's Name _____ Female ___ Male ___ DOB _____
Legal Guardian (if a minor - under 18 years of age) _____
Single ___ Married ___ Divorced ___ Widowed ___ Soc. Sec. # _____
Street Address _____ City _____ Zip _____
Home Phone () _____ Cell Phone () _____
Occupation _____ Employer _____
Employer Address _____ Work Phone _____
Driver's License Number _____ Exp. Date _____

Insurance Information (copy of cards required)

*Copayments and Coinsurance Payments are due at the time of your visit.
No insurance: Payment is due in full at the time of your visit.*

Primary Insurance _____ Member # _____
Insured's Name _____ Group # _____
Billing Address _____ City _____ Zip _____
Secondary Insurance _____ Member # _____
Billing Address _____ City _____ Zip _____
Authorization # _____

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE OFFICE POLICY. THE PATIENT OR LEGAL GUARDIAN IS RESPONSIBLE FOR PAYMENT ON THIS ACCOUNT. CANCELLATIONS MADE WITH LESS THAN 24 HOURS NOTICE AND APPOINTMENTS NOT ATTENDED WILL BE BILLED TO THE PATIENT AT THE FULL FEE. DELINQUENT ACCOUNTS ARE REFERRED TO COLLECTIONS AND THE PATIENT IS RESPONSIBLE FOR A \$50 PROCESSING FEE IF ACCOUNT IS TURNED OVER TO COLLECTIONS.

I have read the above and agree to the terms of this office.

Signature of Patient or Legal Guardian

Date of Appt.