DALJIT S. BUTTAR, M.D.

Demographic Form

PATIENT INFORMATION

Patient Name: _____
Last First MI

Date of Birth: _____ Sex: F___ M___ Social Security Number:_____

Address: _____City_____State_____Zip_____

Marital Status: M __ S __ D __W__ Email address:_____

Primary Telephone: _____Alternate Telephone: _____

Employer: _____ Occupation: _____

Race (circle one): Caucasian, African American, American Indian, Alaska Native, Asian/Pacific Islander, Other

Ethnicity (circle one): Hispanic, Non-Hispanic, Unknown

Language: _____

1. Is there a Workers' Comp claim involved with this injury? **Yes _____** **No _____**

2. Is this an on-the-job injury? **Yes _____** **No _____**

3. Has this visit been approved through Workers' Comp? **Yes _____** **No _____**

Emergency Contact:_____ Relationship: _____ Phone: _____

PATIENT INSURANCE INFORMATION**Please provide Insurance Card and Photo ID to Receptionist

Primary Insurance Company: _____

Name of Policy Holder: _____ Date of Birth_____

Insurance ID Number: _____ Group Number: _____

Secondary Insurance Company: _____

Name of Policy Holder: _____Date of Birth_____

Insurance ID Number: _____ Group Number: _____

PATIENT REFERRAL INFORMATION

Primary Care Physician_____Phone_____

Referring Physician_____Phone_____

Referred by: □ Physician □ Our website □ Newspaper ad □ Google ad □ Yellow pages □ Family/Friend □ Other_____

I hereby authorize Daljit S. Buttar, M.D. to furnish all necessary information to my insurance carriers concerning my illness and treatment. I further authorize benefits payments to be made directly to Daljit S. Buttar, M.D. I understand that I am responsible for all fees regardless of insurance.

Signature: _____ **Date:** _____

DALJIT S. BUTTAR, M.D.

Financial Policy/Consent Form

- All co-pays and/or deductibles are **due at the time of service.**
- We participate with many insurance plans. If we participate with yours that means that we will accept the fee schedule agreed upon by Dr. Buttar and the insurance company. You are, however, responsible for any copay, coinsurance and/or deductible as deemed by your policy.
- Please be aware that the procedures offered at our practice may be considered outpatient surgery by your insurance company, and therefore subject to deductibles and/or coinsurance.
- Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $50.00 for an office visit. All procedures and diagnostic testing not cancelled at least 48 hours will be assessed at a rate of $125.00.
- Your account balance is your responsibility whether your insurance company pays or not. All account balances are due **prior to your next appointment**. **Any outstanding balance over 60 days will be turned over to our collection agency along with a $25.00 collection service fee. You will also be held liable for all reasonable cost of collections and attorney fees.**
- Dr. Buttar and associated practitioners act as specialists in treatment of spine related neurological disorders and headaches, and are not general healthcare providers.
- Refills, if deemed necessary, are given at office visits.
- I will inform Dr. Buttar of all medications prescribed by any other physician treating me for any medical condition related or unrelated.
- I understand that there are rare side effects of any medication or minor medical procedure. Upon accepting a medication or minor procedure, I acknowledge the unlikely possibility of serious consequences and accept these risks with the understanding that these risks are balanced against the effects and risks of medical illness without treatment.
- I understand that it is my responsibility to inform Dr. Buttar if I am pregnant, if there is a possibility of pregnancy, or I am attempting to conceive before any treatment or medication is rendered, and to accept responsibility for any consequences if I have not done so.
- I understand that I may refuse any treatment, medication, or procedure if I do not feel adequately informed or am uncomfortable assuming the risks of treatment.
- By signing this form, I have read and agree to the above.

_____ _____

Signature Date