Dr. Abraham Betre D.O.

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Date:_____/_____/_____

All Information is confidential.

PATIENT INFORMATION ***(PLEASE PRINT)***

Patient Name: _____ DOB:_____/_____/_____

SSN:_____/_____/_____ Marital Status (Circle): Married Single Divorced Widowed

Address: _____ City: _____ Zip: _____

Home Phone: ( ) _____ Mobile Phone: ( ) _____

Email address: _____ Race: _____

Pharmacy: _____ Street/City: _____

Are you (Circle): Full time Part time Self Employed Unemployed Retired Student

Employer: _____ Work: ( ) _____

INSURANCE INFORMATION

Primary Insurance: _____

Member ID: _____ Who's Insured: Self Parent Spouse Other

Do you have another insurance: Yes No

ALTERNATIVE CONTACT

Name:_____ Phone: ( ) _____

Relationship to you: _____

By Initialing and signing below, I agree to the following

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I agree to pay at the time of visit all fees not covered by my insurance, including CO-PAYS. I have 30 days to appeal any charges deemed unreasonable. I also hereby authorize payment of insurance benefits otherwise payable to me directly to Abraham Betre DO.

Initial _____

APPOINTMENT CANCELLATION / NO SHOW FEE

If an appointment is not cancelled at least 24 hours in advance you will be charged a $50 fee; this is not covered by your insurance company.

Initial _____

SURGERY CANCELLATION/NO SHOW FEE

If a scheduled surgery is not cancelled 5 days prior to your procedure you will be charged a fee of $150; this is not covered by your insurance company.

Initial _____

Signature:_____ Date:____/_____/_____