

**Dr. David R. Chapman and Dr. Brent J. Barood**

*Welcome to our office...*

**PATIENT INFORMATION:**

LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ M.I: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ OTHER PHONE: \_\_\_\_\_

HAVE YOU PREVIOUSLY RECEIVED MEDICAL TREATMENT UNDER ANOTHER  
LAST NAME? YES NO IF YES, NAME: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

EMPLOYMENT: (Please circle) Retired Full-time Part-time None

EMPLOYER NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

**INSURANCE INFORMATION:**

Our office staff will need to make a photocopy of your insurance card(s)

PRIMARY INSURANCE COMPANY NAME: \_\_\_\_\_

INSURER'S NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

SECONDARY INSURANCE COMPANY NAME: \_\_\_\_\_

INSURER'S NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

**FINANCIALLY RESPONSIBLE PARTY, IF OTHER THAN SELF:**

LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ M.I: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ OTHER PHONE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ SEX: \_\_\_\_\_

**Dr. David R. Chapman and Dr. Brent J. Barody**

*Welcome to our office...*

**FINANCIAL RESPONSIBILITY AGREEMENT**

- ◆ Payment is required at the time of service. Payment may be made by cash, check or major credit card. Any deductible, co-insurance or co-payment is payable at time of service.
- ◆ The verification of insurance benefits does not guarantee payment of benefits at the time of service. The undersigned agrees, whether being patient or guarantor, to guarantee payments of the account in accordance with the standard rates and terms of Dr. David R. Chapman and Dr. Brent J. Barody. I further understand that any balance remaining after insurance approves or denies payment is my responsibility to pay.
- ◆ Dr. David R. Chapman and Dr. Brent J. Barody reserve the right to transfer unpaid balances to outside entities for collection, such as banks or other financial institutions.
- ◆ I authorize Dr. David R. Chapman and Dr. Brent J. Barody to release any medical information (including, but not limited to, information relating to mental health evaluation and treatment, sickle cell anemia, alcohol and drug abuse diagnosis and treatment, HIV status, AIDS or AIDS related diagnosis, if any such information exists) to all my insurance carriers, third party payers, including Health Care Financing Administration (Medicare) or its agents, or the Social Security Administration, as may be required or requests for the processing of health insurance claims. I request payment of the benefits to be made directly to Dr David R. Chapman.

I have read and understand all of the above and have given truthful information to the best of my knowledge.

---

**Signature & Date**