Laura Jozewicz, MD, PA.
701 Exposition Place, Suite 106 Raleigh, NC 27615
Ph. 919.845.2580. Fax 919.845.2581

Patient Information

Name : _____
Last First Middle
Address : _____City:_____ State:_____ Zip:____

Home Phone: ( )_____ Work : ( )_____Cell Phone: ( )_____

Date of Birth: ___/____/____ Social Security # ____-_____-_____ Sex: M F

Marital Status: _____ In case of Emergency: _____

Insurance Information:

Policy Holder:_____ ; His/Her DOB _____

Primary Insurance:_____ Policy Number:_____

Secondary Insurance:_____ Policy Number:_____

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment to Laura Jozewicz, MD, P.A. all benefits, if any, otherwise payable for the services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

CREDIT POLICY:
For services rendered, a claim will be filed with your insurance carrier. HOWEVER, ALL DEDUCTIBLES,CO-PAYS AND PERCENTAGE ARE TO BE PAID ON THE SAME DAY SERVICES ARE RENDERED. We accept cash, check, Master Card and Visa. You will be notified when final action by your insurance has been received. If any funds are due, payment is expected with in thirty-days upon receipt of your statement.

CANCELLATION POLICY:
I hereby understand that if I need to cancel my appointment I must give a 24- hour notice otherwise I will be charged a $50.00 cancellation fee for any missed office appointment or an EMG appointment.

AUTHORIZATION FOR RELEASE OF INFORMATION:
I hereby au authorize Laura Jozewicz, MD, P.A. to release any medical or incidental information that may be necessary for either medical care or in processing of claims for financial benefits. Laura Jozewicz, MD, P.A. may be authorized to release my protected health information to my spouse and/or other family members as needed unless specified, I may be contacted at my home/work/cell-phone or any telephone number provided. I understand I have the right to revoke this authorization at any time.

PATIENT PRIVACY POLICY
I have received and/or read a copy of the Notices of Privacy Practices from Laura Jozewicz, MD, PA.

WORKMAN'S COMPENSATION POLICY:
We do not accept Workman's Compensation cases. By Signing below, I certify that this visit is not a compensation- related visit.

I HAVE READ AND UNDERSTAND THE TERMS AND POLICIES AS STATED ABOVE.

_____ _____
PATIENT'S SIGNATURE (or legal guardian) DATE