



John J. Eck, M.D.  
Board Certified Family Physician

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Board Certified Family Physician

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Physician Assistant

**Patient Information**

Please Complete All Sections

Name (First, MI, Last) \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Sex: M F  
Mailing Address (street) \_\_\_\_\_ Apt# \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Daytime Phone (\_\_\_\_) \_\_\_\_\_ Mobile Phone(\_\_\_\_) \_\_\_\_\_  
SS# \_\_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed  Separated  
Email Address \_\_\_\_\_ Would you like to receive emails from us? Yes No  
Employer \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Name of referring physician \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_  
Other family members that are patients: \_\_\_\_\_

**Parent, Spouse, or Responsible Party**(statements will be addressed to responsible party)

Name (First, MI, Last) \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Sex: M F  
Mailing Address (street) \_\_\_\_\_ Apt# \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Daytime Phone (\_\_\_\_) \_\_\_\_\_ SS# \_\_\_\_\_  
Employer \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Patient's relationship to Insured:  Self  Spouse  Child  Step-child  Other \_\_\_\_\_

**Insurance Coverage-Primary**

Name of Policy Holder (Insured) \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Insurance Comp. Name \_\_\_\_\_ Insurance Phone# (\_\_\_\_) \_\_\_\_\_  
Policy Holder's Social Security # \_\_\_\_\_  
Address of Claim Center (street, city, state, zip) \_\_\_\_\_  
Policy # \_\_\_\_\_ Group Name \_\_\_\_\_  
Group Number \_\_\_\_\_  
Employer \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_  
Employer Address \_\_\_\_\_

**Insurance Coverage-Secondary**

Name of Policy Holder (Insured) \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Insurance Comp. Name \_\_\_\_\_ Insurance Phone# (\_\_\_\_) \_\_\_\_\_  
Address of Claim Center (street, city, state, zip) \_\_\_\_\_  
Policy Holder's Social Security # \_\_\_\_\_ Policy # \_\_\_\_\_  
Group Name \_\_\_\_\_ Group Number \_\_\_\_\_  
Employer \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Patient's relationship to Insured:  Self  Spouse  Child  Step-child  Other \_\_\_\_\_

## Patient Information

Continued

### In case of emergency

Name of friend or relative not residing with you \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Address \_\_\_\_\_

Day phone# (\_\_\_\_) \_\_\_\_\_ Evening phone# (\_\_\_\_) \_\_\_\_\_

### Pharmacy Information

Pharmacy Name \_\_\_\_\_

Address \_\_\_\_\_

Phone number# (\_\_\_\_) \_\_\_\_\_ Fax number# (\_\_\_\_) \_\_\_\_\_

### How did you hear about Center For Lifetime Health?

\_\_\_\_\_

### Release of information and assignment of benefits:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize CENTER FOR LIFETIME HEALTH or insurance company to release any information required to process my claims.

IN ADDITION, I acknowledge that I have been informed of the CENTER FOR LIFETIME HEALTH'S Notice of Privacy Practices.

### Payment Policy

Payment is required for all services at the time they are rendered unless you are enrolled in an insurance plan in which we participate. Any **applicable co-payments, co-insurances and/or deductibles will be collected at the time of service.** We accept payment in the form of cash, check or credit card. Your insurance plan will be billed for the charges incurred. Please note that the patient is responsible for any/all charges not paid for by insurance company. Prior authorization does not guarantee payment of claims. If a diagnostic procedure is performed, it is the patient's financial responsibility to pay any balance due to any outside facility utilized to complete and determine the diagnosis for such procedure. **24 hour notification is required to cancel or reschedule an appointment to avoid a \$25.00 fee which is not covered by insurance.** Your signature below signifies your understanding and willingness to comply with these policies.

A \$25.00 "No Show" fee will be charged to your account if you fail to cancel or re-schedule your appointment at least 24 hours in advance. While we will make every effort to provide a courtesy reminder call prior to your visit, it is your responsibility to cancel your appointment.

A fee will be charged for any returned checks.

I have read the Payment Policy and Release of Information described above. I understand and agree to all its provisions.

X \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

PATIENT / GAURDIAN SIGNATURE

DATE