LAKE CONWAY MEDICAL CLINIC
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Orlando, FL 32812
Phone: 407-851-2790
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www.lakeconwayprimarycare.com

PLEASE CIRCLE ONE

- PRIMARY CARE
- IMMIGRATION
- MED CLEARANCE
- QTC

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Patient's last name:	First:	Middle:	Marital status (circle one):	
			Single / Mar / Div. / Sep / Wid	
Race:	Ethnicity:	Preferred Language:	Birth date:	Sex:
			/ /	☐ M ☐ F

Street address:	Social Security no.:	Home/Cell Phone no.:
		( )
City:	State:	Zip code:
Email:	Preferred Pharmacy Name, Address & Phone number:	

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)

Subscriber's name (if other than yourself):	Birth date (if other than yourself):
	/ /

Patient's relationship to subscriber: ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Lake Conway Urgent Care, LLCor insurance company to release any information required toprocess my claims.**All payments received must be made payable to Lake Conway Medical CLinic, LLC. No personal or inconvenient checks accepted.**

Patient / Guardian Signature:

Financial Policy

Paymentis due at the time services are rendered, which includes all deductibles, co-insurance and co-payments. Patients who have an insurance carrier in which the practice has a valid contract with will be responsible for all fees.

Depositsare collected from all Self-Pay patients prior to service. Insurance is filed for all primary carriers. Secondary or supplemental insurance is filed as well. A claim form can be provided at the time of service for the patient to file. Patients are responsible for any charges not covered by insurance or other benefits. This practice, Lake Conway Medical Clinic, LLC, DOES NOT ACCEPT PERSONAL CHECKS OR ANY INCONVIENANT CHECKS. This practice, Lake Conway Medical Clinic, LLC DOES ACCEPT MASTER/VISA/AMEX/DISCOVER CREDIT CARDS OR DEBIT/ CHECK CARDS AND PATIENTS ARE RESPONSIBLE for all fees if transaction is not approved or is expired for any reason from your credit card company.

STATEMENTS AND BILLING CORRESPONDANCE are sent to update the patient as to the status of the account and whether your company had fulfilled their obligation to you, the policy owner, to pay claims in a timely manner.

DELINQUENT ACCOUNTS are sent to collections 90 days from the date services were rendered. Patients having financial difficulties are encouraged to discuss them freely with us before the account becomes delinquent.

General Consent

I/we hereby authorize Lake Conway Medical Clinc, LLC, to furnish information and/ or discuss information contained in my medical record, including appointment information, with the following person/persons:

Name: ______________________ Relationship: ______________________

I/We have provided my general information/insurance information correctly, have read the Financial Policy for Lake Conway Medical Clinic, LLC and also understand and acknowledge the general consent above.

Signature: ______________________ Date: ______________________