Jennifer L. Lakis, DO

15 Sky View Drive (p) 207-798-9677
Cumberland Foreside, ME 04110 (f) 207-569-6730

All Bolded fields on this page are MANDATORY, thanks.

Date: _____
Patient's Legal Name: _____ Name you go by**:_____**
Date of Birth: ____/____/_____Current Age: _____
Sex: M F Marital Status: _____
Street Address: _____
City: _____ State:_____ Zip code: _____

Primary Phone: _____ type: cell/home/work
Alternate Phone: _____ type: cell/home/work
Email address: _____

Emergency Contact:_____ Phone:_____
Spouse or Parents Name: _____

Primary Care Physician: _____ Phone: _____
Address: _____
Referring Physician: (if different from PCP) _____

Occupation: _____Employer: _____

Person responsible for payment (if not above) _____
Name and date of birth of Primary cardholder: _____
Phone: _____ Address: _____
City, State, Zip: _____
Primary Insurance: _____ ID# _____
Secondary Insurance: _____ ID# _____

Is this a work-related Injury? Y N Has your employer been notified? Y N
Date of Injury: _____ Claim # _____ Adjuster: _____
Adjuster's Phone: _____ Adjuster's Fax: _____

Is this injury a result of an accident? Y N Date of Accident: _____
Claim # _____ Attorney: _____

<u>*IMPORTANT, PLEASE READ*</u>

Please contact your primary care physician to make sure a referral has been sent to us if your insurance carrier requires one. You are fully responsible for payment in the event we do not receive the appropriate insurance referral authorization prior to your date of service. If you have an HMO plan, you most probably do need a referral from your PCP, which would include an insurance provider recognized referral authorization number, number of visits and expiration.

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- **NOTICE OF ACKNOWLEDGEMENT:** I acknowledge that I have received the notice of privacy practices posted in the office, and that a copy of our privacy practices is available both on our website and to me upon request.
- Signature: _____ Date: _____
- Print Name: _____ DOB: _____

- **AUTHORIZATION OF PAYMENT:** I authorize payment of my medical benefits to Jennifer Lakis, D.O. for services rendered. I understand that I am financially responsible in the event that payment is denied or rejected by the insurance company and for those charges not covered by policy benefits, as well as deductibles and co-insurance that are not covered by this assignment.
- Signature: _____ Date: _____

- **RELEASE OF NECESSARY MEDICAL INFORMATION:** During the course of my treatment I understand that certain tests, such as an MRI, CT Scan, or consultations with other physicians may be necessary. I authorize the release of any medical information for these purposes. I authorize the release of any medical information for these purposes. I authorize the release of any medical information necessary to process my disability and/or medical claim.
- Signature: _____ Date: _____

- **LATE CANCEL AND NO-SHOW POLICY:** All patients are granted one late cancel without additional charge per calendar year. There is a $25 charge for any appointment cancelled less than 24 hours of the scheduled time. There is a $100 charge for any no-show to an appointment. I understand that arriving more than fifteen minutes late for any scheduled appointment will be considered a no-show and treatment is not guaranteed.
- Signature: _____ Date: _____

MEDICARE PATIENTS ONLY

- **MEDICARE RELEASE OF NECESSARY MEDICAL INFORMATION**: I authorize any holder of medical or other information about me to be released to the social security administration, health care financial administration or it's intermediaries/carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignments, I understand it is mandatory to notify the health care provider or any other party who may be responsible for paying for my treatments of any changes. (Section 1128(B) of the social security act and 31 U.S.C. 3801-3812 provide penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.
- Signature: _____ Date: _____

FOR OFFICE USE ONLY

DOCUMENTATION OF GOOD FAITH EFFORTS: the patient presented for treatment on this date and was provided with a copy of the notice of privacy practices. A good faith effort was made to obtain a written acknowledgement or receipt of the notice. However, an acknowledgement was not obtained for the following reason: _____. Patient name: _____

Signature of physician or employee: _____ Date: _____