Barry K. Knezek, M.D.
PATIENT REGISTRATION and FINANCIAL POLICY

Today's Date: _____ / _____ / _____

Patient Name: _____
Last *First* *Middle Initial* *Preferred Nickname*

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

May we contact you by phone for appointment reminders? Yes / No

Preferred Number: Home / Work / Cell Please do NOT call me at: Home / Work / Cell

May we contact you by email? If yes, email address: _____

____ I confirm that email communication with Dr. Knezek's office is an acceptable form of communication. Dr. Knezek's email service is non-encrypted, and therefore, not HIPAA compliant. Please choose a non-email form of communication (mail/phone) if this is not acceptable.

When time permits, we are pleased to provide a reminder phone call or email for your appointment as a courtesy. There may be instances when courtesy reminders cannot be made for your next appointment. ***You are ultimately responsible for remembering your appointment date and time and rescheduling at least 1 day in advance when unable to attend your scheduled session****. Unless your appointment is canceled at least 24 hours in advance, our policy is to charge the rate of a normal office visit.*

Employed: Yes / No Student: Yes / No Occupation: _____

SS#: _____-_____-_____ Age: _____ DOB: _____ / _____ / _____

Marital Status: Single / Married / Partnered / Divorced / Separated / Widowed

Significant Other's Name: _____

Emergency Contact: _____ Phone: _____

Referral Source: _____ Phone: _____

FINANCIAL POLICY

1. Payment in full at time of visit is expected unless PRIOR financial arrangements have been made.
2. Payment may be made by cash, check, Visa, MasterCard or Discover.
3. Because Dr. Knezek is not contracted with any insurance companies, patients are expected to pay the full fee at the time of service.
4. We will be happy to provide you with a receipt to file with your insurance company for reimbursement.

INSURANCE

We cannot guarantee payment of your claims or accept responsibility of negotiating claims with insurance companies or other persons. You are responsible for full payment of services rendered. We encourage you to become familiar with your particular insurance benefit plan and philosophy of its administration.

PRIOR AUTHORIZATION OF MEDICATIONS

There may be instances where your insurance is contacted in order to obtain approval for medication. By signing below you acknowledge it is okay for information be disclosed, including current and previous medications and in some cases, medical record notes.

FEES

Our standard fees will apply in most situations. Occasionally it is necessary to extend a session to ensure proper treatment and/or to address complications/emergencies. You will be charged accordingly for your required session time.

FOLLOW-UP APPOINTMENTS

In order to provide the best care for his patients, Dr. Knezek requires follow-up appointments at least once every 6 months. We recommend that you schedule your next follow-up appointment when you are checking out in order to secure a date. If a conflict arises, your appointment can always be rescheduled.

Signature: _____ Date: _____ / _____ / _____

Barry K. Knezek, M.D.
CREDIT CARD POLICY and AUTHORIZATION FORM

I grant permission for the office of Barry K. Knezek, M.D., to keep a credit card on file to be charged in the following cases:

1. No Shows/Missed Appointments
2. Late Cancellations (less than 24 hours prior to your appointment time, with the exception of Monday appointments which must be canceled or rescheduled by noon on the preceding Thursday)

I further understand and agree to the following:

1. Fees for my ongoing sessions will be charged to my credit card unless I request to pay by new credit card, cash or check.

WE ACCEPT VISA, MASTERCARD AND DISCOVER

Signature: _____ Date: _____ / _____ / _____

Patient Name: _____

Name on Credit Card: _____

Credit Card Type: _____ Number: _____

Expiration Date: _____ / _____ CVV: _____

Billing Address & Zip Code: _____

_____