MEDICAL PROCEDURES CENTER P.C.

Lorenzo D. Berlanga, M.D.
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Midland, MI 48640
(989) 631-4545 Fax (989) 631-9949
Visit our Web Site at: MPCenter.net

NEW PATIENT INFORMATION

DATE: | **REFERRING PHYSICIAN:**

PATIENT DATA

PATIENT'S LEGAL NAME (LAST, FIRST, MIDDLE)			MARITAL STATUS (Circle One) M S W D		PREVIOUS NAME / EMAIL ADDRESS	
STREET ADDRESS	P.O. BOX		SEX	AGE	DATE OF BIRTH / /	SOCIAL SECURITY NO.
CITY STATE ZIP CODE			PATIENT'S TELEPHONE NO. Home: Cell:			PATIENT'S WORK TELEPHONE NO.
EMPLOYED BY	EMPLOYER'S ADDRESS				PATIENT EMPLOYMENT STATUS - CIRCLE ONE: Full Time, Part Time, Active Military, Retired (Date: / /), Self, Not	
PREVIOUSLY TREATED HERE YES NO YEAR	IT IS OKAY TO GIVE MY MEDICAL INFORMATION TO:					
NEAREST RELATIVE NAME	ADDRESS				TELEPHONE NO.	

EMERGENCY CONTACT

NAME	RELATIONSHIP	TELEPHONE NO. CELL:	
ADDRESS STREET	CITY	STATE	ZIP CODE

POLICY HOLDER

PERSON RESPONSIBLE FOR BILL	ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NO.	RELATIONSHIP	DATE OF BIRTH / /	EMPLOYER	SOCIAL SECURITY NO.
EMPLOYER'S NAME	ADDRESS STREET	CITY	STATE	TELEPHONE NO. CELL:

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME:

POLICY HOLDER:

SECONDARY INSURANCE COMPANY NAME:

POLICY HOLDER:

PLEASE BRING INSURANCE CARDS AND DRIVERS LICENSE OR OTHER FORM OF ID WITH YOU TO YOUR APPOINTMENT.

* PLEASE TURN OVER AND FILL OUT BACK SIDE *

PRE-AUTHORIZED HEALTH CARE PAYMENT AGREEMENT

We can bill your credit card **AUTOMATICALLY** once the insurance/patient balance is settled.

☐ Bill my credit card automatically for my account balance after insurance.

☐ Payment Plan – charge my credit card _____ each month for (4) months.

☐ I will pay my account in full after I receive my first statement from Medical Procedures Center (approximately 30 days from service date) with cash, check, money order or credit card. If my balance is not paid within 45 days from service date, Medical Procedures Center will contact me to obtain permission to pay my balance with the credit card provided below.

Medical Procedures Center will apply a $35.00 fee on all checks returned for insufficient funds.

The Medical Procedures Center PC has my permission to charge any balance of my health care fees to my credit card unless I have paid them in full. I understand I will be notified before this is done.

Type of Card ☐ VISA ☐ MasterCard ☐ Discover

Card Number _____ Exp. Date _____/_____ Three or four digit Code on Back _____

Name on Card _____

Signature _____

INSURANCE AUTHORIZATION

I, the undersigned, do hereby authorize The Medical Procedures Centers, P.C., to furnish to insurance companies information concerning my illness and treatments and I hereby assign benefits to the physician for all medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance or participation agreements and I am responsible to obtain any second opinions or referral slips to enhance billing. A photocopy of this agreement is to be considered as valid as an original. If you are under 18 years of age, please have a parent or guardian sign.

DATE _____ SIGNATURE _____

Relationship

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by this provider. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services. In the event that a service is not a covered benefit for Medicare, I agree to pay for services rendered.

DATE _____ SIGNATURE _____

Relationship

WE PARTICIPATE WITH BLUE CROSS/BLUE SHIELD OF MICHIGAN, HEALTH PLUS, MEDICARE, DOW, DOW CORNING, CONNECT CARE AND MEDICAID. WE WILL SEND IN YOUR BILL FOR YOU. ALL PATIENTS ARE RESPONSIBLE FOR DEDUCTIBLES, CO-PAYS, AND "NON-COVERED" SERVICES, REGARDLESS OF INSURANCE. THE PATHOLOGY LAB AT THE HOSPITAL WILL BILL YOU OR YOUR INSURANCE FOR ANY SPECIMENS SENT TO THEM FOR EVALUATION.