Welcome To Our Office!

Patient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____
Work or Cell Phone: _____
Birthdate: _____ Social Security Number: _____
Sex: male female Marital Status: married single divorced widowed
Occupation: _____
Employer: _____
Status: employed retired unemployed student

Name of any referring physician: _____

Name of your primary care physician: _____

Primary Insurance Company:_____
Claims Address: _____
City: _____ State: _____ Zip: _____
Insurance policy holder: _____
Address (if different from patient): _____
City: _____ State: _____ Zip: _____
Home Phone: _____
Work or Cell Phone: _____
Birthdate: _____ Social Security Number: _____
Patient's relationship to policy holder: _____
Sex: male female Employer: _____
Insured's ID number: _____
Policy Group Number:

1. Patients are responsible for all payments including, but not limited to co-pays, co-insurance, deductibles, and past due balances at the time of service. We accept cash, check, debit cards, and all credit cards.
2. Please call us at least 24 hours before your appointment time if you need to reschedule, change, or cancel an appointment. A $25.00 charge will be applied for appointment that is not cancelled at least 24 hours prior to your appointment time. A deposit of $ 200.00 may be required for all surgical appointments. If the appointment is missed and not cancelled at least 24 hours before your appointment time, the deposit will not be refunded.

I have read and understand the financial policy of Kevin Lunde M.D. , and I agree to be bound by its terms. I understand and agree that such terms may be amended in the future by the practice.

Print Name Signature Date

Patient's Name:

How did you learn about our practice? *(circle all statements that apply)*

- My doctor _____ referred me.
- My friend _____ told me about you.
- Your office is convenient.
- I noticed your name in the yellow pages.
- The hospital referral service recommended you.
- You are on my insurance plan.
- I saw your web site www.KevinLundeMD.com
- The web site _____ had you listed.
- I saw your ad in _____.
- Other:

E-mail address: _____May we send information there? Yes No

Emergency contact not living in household: _____

Name: _____ Home phone: _____

Relationship: Work / cell phone:

Our office will file insurance for all reimbursable services to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductibles, copays, and non-covered service amounts. We ask that you make any required payments at the time of check in. You may review our payment policy or ask our staff if you have any questions.

Consent for Release of Health Information

I hereby permit Kevin Lunde, MD, PA to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or other third party payers, or any organizations contracting with any of the above entities to perform such functions.

Signed: _____ Date: _____
Patient or responsible party

Acknowledgement of Review of Privacy Policy

I have reviewed this office's Notice of Privacy Practices that explains how my health information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signed: _____ Date: _____
Patient or responsible party

I authorize the payment of my medical and surgical insurance benefits to Kevin Lunde, MD, PA

Signed: _____ Date: _____
Patient or responsible party