

Yuma Valley



FAMILY MEDICINE CENTER, PC

Tel: (928) 782-1903

Fax: (928) 782-1703

Patient Name: _____ Date of Birth: _____

Street Address: _____

Mailing Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Social Security #: _____

Marital Status: () Married () Single () Divorced () Widowed

Insurance Information

Primary Insurance: _____ Subscriber ID: _____

Subscriber Name: _____ Date of Birth: _____

Secondary Insurance: _____ Subscriber ID: _____

Subscriber Name: _____ Date of Birth: _____

Employer Information or School Name

Employer Name: _____ Phone Number: _____

Address: _____

Additional Information

Emergency Contact Name: _____ Relation: _____

Phone Number: _____

Pharmacy Name: _____

Major Cross Streets: _____

I request that payment under my insurance program be made to either me or on my behalf to Yuma Valley Family Medicine Center, PC for any services furnished to me by Dr. Ricky Ochoa or associates. I authorize the release of any medical information necessary for the purpose of evaluating benefits or processing of a claim.

I understand that I am responsible for payment of my account regardless of insurance coverage. In the event that I do not pay for services provided by this office and the account is placed for collection; I or we understand and agree that an additional amount equal to 20% of the balance owing at the time the account is placed for collection will be added to the current balance owing. In addition to a collection fee of 20% of the balance owed, I or we agree to pay interest at the rate of 18% per annum until the amount is paid in full. I or we further agree to pay all attorneys fees and court costs necessary to collect this balance.

I agree to a \$25.00 charge for missed appointments not cancelled or re-scheduled at least 24 hours in advance of the date of my scheduled appointment. This charge cannot be charged to my insurance.

Patient Signature: _____ Date: _____