KELLY W. HUBBARD, MD · JACOB STEWART, MD · MICHAEL HADLEY, MD
JEFFREY C. BAUGH PA-C · KENT WHITAKER, PA-C· MICHELLE BAILEY, FNP
PATIENT INFORMATION

Name_____ Soc.Sec.No._____ Date_____

Address_____ City_____ State_____ Zip_____

Billing Address (if different) _____ City_____ State_____ Zip_____

Phone_____ Cell Phone _____ Birthday_____ (Circle) M F Married-Single-Widowed-Divorced

Race_____ Ethnicity_____ Language_____

Email_____ Primary Care Physician_____ Phone_____

Name & Address of Employer_____ Wk.Phone _____

Spouse (or) Parent Name _____ Soc.Sec.No._____

Spouse (or) Parent Employer_____ Wk.Phone_____

Emergency Contact_____ Phone_____

Person Responsible for Account_____ How did you hear about us?_____
Do we have your permission to:

Leave a message on your answering machine at home? Yes □ No □
Leave a message at your place of employment? Yes □ No □
Discuss your medical condition with any member of your household? Yes □ No □

If yes, Whom:_____ Relationship:_____

INSURANCE INFO

PRIMARY Insurance Company_____ Policy or I.D. No._____

Name of Policy Holder_____ Birthday_____ Soc.Sec.No._____

Insurance Co. Address_____ Phone_____

SECONDARY Insurance Co._____ Policy No._____

Name of Policy Holder_____ Birthday_____ Soc.Sec.No._____

Insurance Co. Address_____ Phone_____

Authorization to Treat and Insurance Policy

I authorize the use of this mobile phone number (as listed above) to receive billing text messages. I agree to update this office if this mobile number changes.**We will be happy to submit all insurance claims if you provide us with your COMPLETE insurance information at the time of your visit. You are responsible for all co-pays, deductibles, and charges not covered by insurance. It is our policy to require payment on all office charges at the time they are given, unless prior arrangements have been specifically made...**In the event of default and referral to an attorney or collection agency, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency. I agree to pay all collection cost including reasonable attorney fees.

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also authorize payment of insurance benefits otherwise payable to me directly to the doctor. * I give the consent for Dr. Kelly Hubbard, Dr. Jacob Stewart, Dr. Michael Hadley, Jeffrey C. Baugh, PA-C, Kent B. Whitaker, PA-C and/or Michele Bailey FNP to treat me or my child.

**** I understand that this office is in compliance with all HIPPA regulations, and a brochure and full disclosure is available to me upon request.**

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Signature of Patient (or parent if minor) Date