EAST IDAHO
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RICHARD G. LEE, MD

PATIENT INFORMATION

How did you hear about us (referring doctor)?: _____

First Name:_____ MI:_____ Last Name:_____

Date of Birth:_____ Age:_____ Social Security #:_____

Sex: Male ☐ Female ☐ Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Race: White ☐ Hispanic ☐ African American ☐ Asian ☐ Other: _____

Ethnicity: _____ Preferred Language: _____

Mailing Address:_____

Street *City* *State* *Zip*

E-mail address:_____ Preferred Pharmacy: _____

Employer: _____ Occupation: _____

Spouse/Guardian (if applicable):_____ Phone: _____

Emergency Contact:_____ Phone: _____

Patient's Relationship with Contact: _____

INSURANCE INFORMATION

PRIMARY Insurance Company: _____ Group No:_____

Address: _____ Phone: _____

Name of Policy Holder: _____ Policy No: _____

Policy Holder's SSN: _____ Policy Holder's DOB: _____

Patient's Relationship to Policy Holder: _____

SECONDARY Insurance Co: _____ Policy No: _____

INFORMATION RELEASE

I hereby authorize Dr. Richard G. Lee to release any information acquired in the course of my examination or treatment to the Insurance carriers.
I hereby authorize any physician, hospital, or medical care facility to provide all information on my medical history and treatment to Dr. Richard G. Lee.
Please Read & sign below. **I acknowledge that I have received a copy of the HIPPA Policy and agree to its terms** (available for review at our website: www.eastidahoent.com).

I AUTHORIZE DR. RICHARD G. LEE TO RECEIVE ASSIGNMENT OF INSURANCE PAYMENTS. IF THE CUSTOMARY CHARGES ARE MORE THAN THE BENEFITS ALLOWED UNDER RESPONSIBLE PARTY'S INSURANCE PLAN, I AGREE TO PAY THE DIFFERENCE.
I UNDERSTAND THAT REGARDLESS OF INSURANCE COVERAGE I AM REPONSIBLE FOR ALL CHARGES AND PAYMENTS (POLICY AVAILABLE FOR REVIEW AT EASTIDAHOENT.COM). I FUTHER UNDERSTAND THAT MISSED APPOINTMENTS WHICH ARE NOT CANCELED IN ADVANCE OF 24 HOURS WILL BE CHARGED A FLAT FEE OF $15 AND THAT THIS FEE IS NOT PAYABLE BY MY INSURANCE COMPANY. A 12% ANNUAL INTEREST RATE WILL BE CHARGED FOR OUTSTANDING BALANCES AFTER 90 DAYS.

I further authorize the doctor's office to make photocopies of this authorization and assignment, in order for them to attach a copy to any insurance form and to be able to retain the original copy in the doctor's files and authorize the insurance company to accept the photocopy. I release Dr. Richard G. Lee from all legal responsibility or liability that may arise from this authorization. This authorization shall continue and be in force and effect until revoked in writing by me, the responsible party.

_____

RESPONSIBLE PARTY'S SIGNATURE DATE