

PATIENT CHANGE FORM

Patient Name _____ Sex: M F Date of Birth _____

Address _____ City/State/Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ Marital Status S M W D Par Age _____ SS# _____

Employment Y N _____ Student Y N _____

Primary Care Physician _____ Address/Phone _____

Referred by _____ OK to leave messages at home phone? Yes _____ No _____

Emergency Contact _____ Phone _____ Rel. _____

If the patient is a minor: The child lives with Both Parents _____ Mother _____ Father _____

If the parents are divorced or separated, the PARENT WHO BRINGS THE CHILD will be the guarantor of this account

Mother/Guardian _____ Phone _____ Address _____ SAA

Father/ Guardian _____ Phone _____ Address _____ SAA

Primary Insurance Co. _____ Secondary Insurance Co. _____

Subscriber Name _____ Copay\$ _____ Subscriber Name _____ Copay\$ _____

Rel.: Self Spouse Child DOB: _____ Rel.: Self Spouse Child DOB: _____

Employer _____ SS# _____ Employer _____ SS# _____

I give permission for clinicians at Diane Eden MD & Associates Inc to evaluate and treat me or the person for whom I am the legal guardian. I also authorize tests, procedures and medications deemed necessary and mutually agreed upon by me and the clinician(s). I understand that I am responsible for payment to Diane Eden MD & Associates Inc for any services rendered to me or my minor child. I understand that if I cancel an appointment with less than 24 business hours notice or if I do not show up to a scheduled appointment that I have not cancelled, that I will be billed for the appointment time reserved and that my insurance company will not cover this charge. I understand this charge must be paid prior to the next date of service. I understand a \$25.00 billing fee will be added for fees not paid at the time of service. I understand that I am financially responsible for payment for all co-payments, deductibles, coinsurance and any other charges deemed my responsibility and not covered by my insurance company, and that these charges are to be paid at the time of service. I understand that I am responsible for payment if referrals required by my insurance are not obtained by me. If Diane Eden MD & Associates Inc files insurance claims on my behalf, I hereby authorize payment to Diane Eden MD & Associates Inc for such services. I permit a copy of this authorization to be used in place of the original. I understand that if my account balance should go over 60 days that I will be expected to pay in full and seek reimbursement from my insurance company unless other arrangements have been made with the billing department. I understand that after 60 days, my account will incur finance charges and late charges. I understand that the parent who brings in a minor for treatment is the financially responsible party. Should my account be referred to a collection agency, I am aware that I will be responsible for all fees associated. I authorize and give consent to Diane Eden MD & Associates Inc to discuss my care and relevant financial information with attorneys, accountants, insurance carriers (malpractice and health), billing agents and collection companies as deemed necessary. This release includes all services relating to my medical care.

Patient/Guardian Signature _____ Date _____

Clinician _____ DSM IV _____ Date _____

Clinician _____ DSM IV _____ Date _____

Clinician _____ DSM IV _____ Date _____