❑ New Patient
❑ Change of info

JOSEPH KUT, MD

PATIENT INFORMATION

Referred By:_____

Patient Name: _____

Address: _____

City:_____**ST:**_____**Zip:**_____

Phone: _____

Date of Birth:_____**Age:**_____

Sex: Male/Female Marital Status: Single/Married/Divorce

Patient Social Security:_____

Employment: Full/Part/Retired Date:_____

Employer:_____

Work Address:_____

City:_____**ST:**_____**Zip:**_____

Work Phone: _____

First Date of Symptoms: _____

Insured Name: _____

Address:_____

City: _____**ST:**_____**Zip:**_____

Phone: _____

Relationship to Insured: Spouse/Parent/Child

Sex: Male/Female Marital Status: Single/Married/Divorce

Insured Social Security:_____

Employment: Full/Part/Retired Date:_____

Employer: _____

Work Address: _____

City: _____**ST:**_____**Zip:**_____

Work Phone:_____

INSURANCE COMPANY:_____**Policy #**_____

Claim Mailing Address:_____**Group #**_____

City:_____**State:**_____**Zip:**_____

Insurance Phone:_____

SECONDARY INSURANCE:_____**Policy #**_____

Claim Mailing Address:_____**Group #**_____

City:_____**State:**_____**Zip:**_____

Insurance Phone:_____

PLEASE PROVIDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD

FOR OFFICE USE ONLY:
DIAGNOSIS:_____
ASSIGNED TO:_____
INSURANCE VERIFICATION: YES_____ **NO**_____
INSURANCE CO-PAYMENT AMOUNT _____ **(PLEASE COLLECT AT EACH VISIT)**

All scheduled appointments must be cancelled 24 hours before the session.
Appointments not cancelled will be billed and will be the patient/guarantor's responsibility.

ASSIGNMENT OF BENEFITS

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have completed all of the attached information. I certify this information is true and correct to the best of my knowledge. I acknowledge that I am responsible for notifying you of any changes.

I authorize the release of medical information and benefits to be paid directly to Joseph Kut, MD.

_____ _____

Signature of Insured **Date**

RELEASE OF INFORMATION

I authorized Joseph Kut, MD or the billing service to release any of the following information for the purpose of obtaining reimbursement/payment for treatment services provided to my dependent or me. The information may include the diagnosis, designated clinical records, and/or the procedure code. This information may be released to any third-party payor having responsibility for payment of charges, review agents or managed care/utilization review agents.

This consent is valid until such time that all claims have been settled or up to 1.5 years from the date of discharge.

I understand that in some cases I and/or some of my dependents may be receiving services for which I am not the insured or for which there is more than one insured. In this case I authorize Joseph Kut, MD to contact the actual or additional insured and to share information necessary to obtain reimbursement for services.

I understand that I can revoke this consent at any time and that I may inspect and copy the information to be disclosed. I can revoke this consent at any time as long as I submit the revocation in writing to Joseph Kut, MD.

I understand that I am ultimately responsible for any and all charges not paid by my medical insurance, and if I refuse to sign this release, I will likely have to pay for any and all charges.

I certify that I am the client and that I understand this form. I can receive a copy of this form upon request. If I am not the patient, I certify that I am authorized as the patient's agent to accept these terms.

Patient's Name:_____

Signature:_____ **Date:** _____