ROBERT C SALTER MSN, CRNP / MICHAEL G GAINES MD

Patient Name: Last_____ First_____ Middle_____

Birthdate:_____ Social Security#:_____ Sex:_____ Race:_____

Address:_____ City:_____State:_____Zip:_____

Phone: Cell_____ Home_____ Email:_____

Driver's License#:_____ Marital Status:_____

Employer:_____ Phone:_____ Retired:_____ Unemployed:____

Primary Insurance:_____ ID#:_____ Group#:_____

Card Holder Name:_____ Relationship:_____

Secondary Insurance:_____ ID#:_____ Group#:_____

Primary Pharmacy:_____ Phone#:_____

How Did You Hear About Us?

Radio_____ Family _____ Friend _____ Facebook _____ BFM Website _____ Other:_____

Person to Notify In Case Of Emergency:_____**Phone:**_____

Consent to Treatment: I consent to necessary treatment, including drug screen, medicine, and performance of operation and conduct of x-ray or other studies that may be used by the attending physician, his nurse or staff.

Authorization for release of information: I authorize BFM LLC. To furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care or my employer who is providing payment of my medical bills due to injury on the job.

Assignments of benefits: I hereby authorize payment directly to BFM LLC. of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but do not exceed the BFM LLC. Charges for these services I understand that I am financially responsible to BFM. LLC not by this assignment. I authorize the refund of overpaid insurance benefits where my coverage are subject to coordination of benefits.

Guarantee of account: For services furnished by BFM LLC. I hereby guarantee the payment of all accounts for service rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Georgia and agree to pay, if necessary all costs off collection, including attorney's fees**, $25 no show fee for office visits, $150 no show fee for ultrasounds and $35 return check fee** that are not covered by insurance.

Patient Signature:_____ **Date:**_____