CRAIG A. RINDER, MD UPDATED__________________________

NAME____DATE OF BIRTH________________

ADDRESS____CITY______________________________

STATE_________ZIP______________PHONE_______________________________________MARITAL STATUS______

IS IT OKAY TO LEAVE A MESSAGE AT YOUR HOME FOR REMINDER APPOINTMENTS? YES OR NO

SOCIAL SECURITY #________________________________EMPLOYMENT____________________________________

IF PATIENT IS A CHILD WE MUST HAVE THE PARENTS NAME

WORK PHONE______________________________PARENT/SPOUSE____________________________________

INSURANCE COVERAGE____________________________SUBSCRIBER NAME_______________________________

SOCIAL SECURITY # OF SUBSCRIBER______________________

ID #'S____GROUP #'S_________________________________

HOW MUCH IS YOUR DEDUCTIBLE? $________________ DO YOU HAVE A COPAY/ IF SO HOW MUCH? $________

WE ACCEPT PERSONAL CHECKS, CREDIT CARDS, CASH OR YOU CAN FINANCE THROUGH CARE CREDIT. THERE ARE NO PAYMENT PLANS OFFERED THROUGH OUR OFFICE, THEY ARE ALL DONE THROUGH CARE CREDIT. THIS IS INTEREST FREE FOR UP TO 12 MONTHS FOR QUALIFIED PATIENTS.

WHO IS YOUR PRIMARY CARE DOCTOR? _____________________________________PHONE_____________________

WHAT PHARMACY DO YOU USE? _____________________________________ PHONE _____________________

Please read the following very carefully and initial each item below

_______**ASSIGNMENT OF BENEFITS**

I hereby authorize Craig Rinder, MD, LLC to furnish information to my insurance carrier (s) concerning my illness and treatment and to bill my health insurance carrier for reimbursement for services provided. I understand that I am ultimately responsible for the cost of the care that I receive. In particular, I agree to pay any amounts not covered by insurance, including co-payments, deductibles and non covered services (including obtaining the necessary referrals as required by your insurance carrier).

_______**CONSENT TO TREAT**

I do hereby give consent to Dr. Rinder and staff under his supervision to provide medical care and treatment.

_______**PRIVACY POLICY**

I have been given the opportunity to review the privacy policy of Craig Rinder, MD, LLC and agree to its terms.

_______**RELEASE OF MEDICAL RECORDS**

I do hereby request that my medical record, currently in the possession____

Be released to Craig Rinder, MD.

Specific information requested: ____.

I request the release of information relating to (circle all that apply):

Treatment of sexually transmitted disease

HIV status

Treatment of psychiatric conditions

Substance abuse treatment

Signature____**Date**________________________