

J. M. Anderson, Jr., M.D.
Charlene Seale FNP-C RNFA
Obstetrics and Gynecology
1500 Coulter, Suite 2
Amarillo TX 79106
Phone: 806-463-5635

RE: New Appointment

Dear Patient:

Thank you for choosing Dr. Anderson and Charlene Seale for your OB/GYN needs. Please review and complete the enclosed packet and bring this information with you to your scheduled appointment. Please arrive 15 minutes early. Do bring your current insurance card and a current list of medications with you. We will also need you to provide a urine sample when you arrive for your appointment. If you have any questions, feel free to call the office and otherwise, we will see you soon!

Sincerely,

Office Receptionist

J.M. Anderson, M.D.
 1500 Coulter, Suite 2
 Amarillo TX 79106
 806-463-5635

Please **Print** Legibly. Complete all applicable boxes/forms.
 If received in the mail, bring packet with current insurance information to your appointment.
 Arrive 15 minutes early.

Patient Name (First, Middle, Last)	Social Security #	Date of Birth	Age	Marital Status S M D W
Mailing Address:	Email Address	Home# ()	Work# ()	Cell Phone# ()
City/State/JZip	_____ @			
Patient Employer Name:	Address	Job Title	Patient Driver License State: _____ # _____	
Spouse's Name: (if under 18 or have parents Insurance please list parent/guardian info for Insurance purposes)	Spouse SSN	Spouse DOB	Spouse Wk#	Spouse Cell#
Spouse's Employer Name:	Address:	Job Title:		
Emergency Contact Name (not in your household)		Phone#	Relationship to Patient	
Address:		Alt#		
REFERRING PHYSICIAN:		PRIMARY CARE PHYSICIAN:		
TO EXPEDITE CLAIMS, PLEASE LIST ALL INFORMATION IN REGARDS TO YOUR CURRENT INSURANCE STATUS				
Insurance Company Name {Primary}	10#	Group#	Customer Service #	
***** If a Dependent Child, Please List Insured's (Parent), DOB, SSN, Address & Phone Number for Billing Purposes				

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

I request that payment of authorized Medicare/Other Insurance company benefits be made on my behalf to J.M. Anderson, MD for any service furnished by the party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release the Social Security Administration and Health Care Financing Administration or its intermediaries, carrier, or other insurance company any information needed for this or related Medicare/Insurance Claim.

I understand my signature request payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 Form is completed, my signature authorizes the release of information to the insurer or any agency shown. In Medicare/Other Insurance cases, the physician agrees to accept the charge determination of the Medicare/Other Insurance company as full charge, and the patient is responsible for only the deductible, coinsurance, and non-covered services.

Signature _____ Date _____