Richard B. Price, MD

5701 West 119TH Street, Suite 320, Overland Park, Kansas 66209
Phone 913-491-3900 www.richardbpricemd.com Fax 913-491-5444

PATIENT INFORMATION

Patient's Legal Name_____Birthdate_____Age_____
First Initial Last

Address_____
Street City State Zip

Phone #s: (H) _____(C)_____(W)_____

☐Single ☐Married ☐Divorced ☐Separated Male Female

Soc Sec Number_____ Email _____

Patient Employer _____ Occupation _____

Prim Care Dr _____Referral Source_____

Emergency Contact _____ Relationship _____

Phone #_____ Alternate Number _____

INSURANCE INFORMATION

Primary Insurance _____Policy # _____ Group #_____

Secondary Insurance _____Policy # _____ Group # _____

Parent/Guardian carrying 2nd policy _____ Employer _____

RESPONSIBLE PARTY INFORMATION

(Responsible Party is defined as the policy holder of the insurance)

Policy Holder's Name _____ Relationship _____

S.S.# _____Date of Birth _____ Employer _____

Address & Phone Number_____
(If Policy holder's address is different than patients address)

Assignment and Release

I request you file my insurance claim(s) for the services provided to me. I assign and authorize payment of benefits directly to Dr. Richard B. Price. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I agree a photocopy of this agreement is as valid as the original.

_____ _____
Patient/Responsible Party Signature Date

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on behalf of Richard B. Price, M.D. for any services furnished me by that physician. I authorize any holder of medical information about me to the Health Care Administration and its agents any information needed to determine these benefits payable to related services.

_____ _____
Beneficiary Signature Date