Stephen M Popkin, M.D.
4100 E Mississippi Avenue #600
Denver, CO 80246
Telephone- 303.759.3215
Fax- 303.759.3515

Date_______________

PATIENT INFORMATION
Name____Date of Birth____________
Home Address (Street)____
City_________________________ State______________ Zip_________________
Home Phone #____________________________Cell Phone #_____________________
Email Address ____
Social Security #________________________ Driver's License #___________________
Status: Single_______ Married_______ Other_______
Employer__________________________Work Phone #_________________________
Occupation____
Employer Address____

SPOUSE INFORMATION
Name____Date of Birth____________
Occupation__________________________ Social Security #_____________________
Employer___________________________ Work Phone #________________________
Employer Address____

IN CASE OF AND EMERGENCY PLEASE NOTIFY
Name_______________________________________ Phone#____________________
Address_____________________________________ Relationship________________

WHO REFEREED YOU TO THIS OFFICE___________________________________
I AGREE TO PAY FOR ALL APPOINTMENTS NOT CANCELED WITHIN TWO FULL BUSINESS DAYS WITH A MINIMUM OF 48 HOURS NOTICE.

Date_________________ Signed____

I UNDERSTAND THAT A $10.00 REBILLING FEE WILL BE CHARGED TO MY ACCOUNT MONTHLY IF IT IS MORE THAN THREE MONTHS PAST DUE.

Date_________________ Signed____

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AUTHORIZATIONS AND AGREEMENTS WITH DR. STEPHEN M. POPKIN. PLEASE READ CAREFULLY AND SIGN. THE PARAGRAPHS CONTAIN SEVERAL ASSIGNMENTS.

Print Patient's Name____

MEDICAL INSURANCE
I authorize the medical insurance company to pay directly for the above physicians services. I, however, understand that both I and the person who signs below are responsible for all my fees, including any fees not paid by the insurance company.

Patient or Parent
Signature____Date__________________

RELEASE OF INFORMATION
I authorize Dr. Stephen M. Popkin to release information about me to the medical insurance company and the referring physician. This authorization will end if I give written instructions to Dr. Stephen M. Popkin, to that effect which I may do at any time.

Patient or Parent
Signature____Date__________________

FINANCIAL RESPONSIBILITY
We, the undersigned, understand and agree that each of us is responsible for the patients fees to Dr. Stephen M. Popkin, including any fees not paid by medical insurance; that if the account is not paid when due, all collection fees and court costs, including the account balance, will be paid by the undersigned; that a rebilling fee of $10.00 per month will be charged on any balance outstanding after 90 days; that we are responsible for full therapy fees resulting from appointments not kept or canceled within two full business days with a minimum of 48 hours' notice; that fees for all services must be paid at the time services are rendered.

Patient or Parent
Signature____Date__________________

Responsible Party Signature________________________________Date________________

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INSURANCE INFORMATION (PRIMARY)
Insurance Company Name____
Phone#____
Address____
PolicyHolder Name__________________________ Relationship to Patient____________
Policy # ___________________________________ Group#________________________

INSURANCE INFORMATION (SECONDARY)
Insurance Company Name____
Phone#____
Address____
PolicyHolder Name________________________Relationship to the Patient__________
Policy# ________________________________Group#_____________________________

ASSIGNMENT OF BENEFITS
I, undersigned, have insurance with ___________________________ and assign directly to Dr. Stephen M. Popkin, all medical benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signed____ Date____________________

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AUTHORIZATION TO BILL CREDIT CARD

I authorize Stephen M. Popkin, M.D., or his designated staff, to bill my credit card for services rendered. I understand these services may include, but are not limited to, scheduled appointments, telephone consultations, review of records and any missed appointment or scheduled appointment not canceled within the 48 hours required notice.

Once my credit card has been charged, I understand that I will receive a receipt of charges.

This authorization shall remain in existence as long as I am a patient of Stephen M. Popkin, M.D., or until I provide a written retraction to this agreement.

I understand that I am responsible for notifying Dr. Stephen M. Popkin of any changes in my credit card status.

Patient Name____
Credit Card #____
CVC2 Code (3 digit code located on the back of card)_________________________
Expiration Date on Card____
Type of Card: Visa______________ MasterCard______________
Cardholder Name____
Cardholder Address (where credit card bill is mailed)_________________________
____

Cardholder Signature____

Witness Name____

Witness Signature___________________________________