Yearly Demographic Update Form

Advanced Laparoscopic Associates
TRUSTED CARE ENSURING HEALTHIER FUTURES

Date:_____ First Name: _____ Last Name:_____

Dob:_____ Age:_____ SSN: _____

Address:_____

Phone Number: _____ Email: _____

Emergency Contact Information

Name: _____ Number: _____ Relationship: _____

Insurance Information

Primary Insurance: _____

Policy #_____ Group#_____

Policy Holder Information *(if different from patient)*

First: _____ Last: _____

DOB: _____ Employer: _____

Does your policy require a referral: ☐ Yes ☐ No

Relationship to insurance holder: _____

Secondary Insurance: _____

Policy #_____ Group#_____

Policy Holder Information *(if different from patient)*

First: _____ Last: _____

DOB: _____ Employer: _____

Does your policy require a referral: ☐ Yes ☐ No

Relationship to insurance holder: _____

Patient Signature: _____ Date: _____

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Patient Name: _____ DOB: _____

I certify that the information given by me in applying for payment either from my insurance carrier or from Medicare is correct.

I authorize this office to release to my insurance carrier or to Medicare any information needed for submission of a claim. I authorize physicians of this office to submit a health claim to my insurance carrier or Medicare.

I authorize my health insurance benefits to be paid directly to Advanced Laparoscopic Associates.

I further agree to be responsible for and to pay off the balance of my bill or my entire, if any of the following events should occur:

- If my insurance policy lapsed or expired at the time I received the services
- If my insurance company decides either before or after my surgery, that my policy did not cover the particular procedure that shall be performed or have been performed.
- If after proper filing of my claim by this office, my insurance company for whatever reason, refuses to pay or fails to process, or fails to pay in a timely manner.
- If I do not promptly turn over any insurance proceeds to this office.

This "Signature on File" is valid for one year from the date indicated below.

Patient Signature: _____ Date: _____