Heather M. Metchick, M.D.
433 North Causeway
New Smyrna Beach, FL 32169
386.427.4441

Name _____ ***Age*** _____ ***Date of Birth*** _____

Address _____

City _____ ***St*** _____ ***Zip*** _____

Home Phone _____ ***Cell Phone*** _____ ***Work Phone*** _____

Primary Physician _____ ***Referred by*** _____

Email _____

Emergency Contact _____ ***Relation*** _____ ***Phone*** _____

Please list anyone with who we are able to discuss your care, finances, etc.:

Name _____ ***Relationship*** _____

Name _____ ***Relationship*** _____

Name _____ ***Relationship*** _____

RELEASE OF INFORMATION, BENEFIT ASSIGMENT, PAYMENT AUTHORIZATION, FULL DISCLOSURE STATEMENT AND AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

I hereby authorize Heather M. Metchick, M.D. to release information necessary to process my insurance/Medicare claim, acquired in the course of my examination or treatment; to allow a photo copy of my signature to be used to process my insurance/Medicare claim for period of **LIFETIME.** I claim any insurance benefits due to me for services rendered by Heather M. Metchick, M.D. and authorize and direct my carrier to issue payment directly to Heather M. Metchick, M.D. regardless of insurance benefits, if any. I understand that I am fully financially responsible for all fees incurred, and I agree to pay such fees in full.The insurance information furnished represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose of pre-certification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges, as a result of non-payment by a carrier. I authorize Heather M. Metchick, M.D. and her staff to call my home or other alternate numbers and leave a message on voice mail or in person in reference to any items that assist the practice, such as appointment reminders, insurance items, and any calls pertaining to my clinical care. A copy of the Notice of Privacy Practices has been given to me.

Patient Signature _____ Date _____
(Parent or Guardian if Minor)