GYFT CLINIC, LLC

- ☐ R.Z. Mc Lees, M.D.
- ☐ Joseph A. Robinette, M.D.
- ☐ Julana Hansmeier, ARNP

Referred by: ______________________________

Last Name: ____________ First Name: ____________ Initial: ______

Address: ______________________________

City: ____________ State: ____________ Zip: ______

Home Phone: ____________ Cell Phone: ____________

Work Phone: ____________ Spouse Work Phone: ____________

Date of Birth: ____________ Social Security: ____________

Employer: ____________ Spouse Employer: ____________

Spouse Last Name: ____________ First Name: ____________ Initial: ______

Spouse Date of Birth: ____________ Social Security: ____________

In Case of Emergency please notify: (other than home phone number please)

Name: ____________ Phone: ____________ Relationship: ____________

Insurance Information ____________ Copay: $ ____________

Primary Insurance: ____________ Ins Phone: ____________

Policy #: ____________ Group#: ____________

Secondary Insurance: ____________ Ins.Phone: ____________

Policy #: ____________ Group#: ____________

Although services may be covered by insurance, I understand I am fully responsible for payment of care received. Insurance coverage and benefits are a contract between the insured and the insurance company. I understand an administrative fee of 1% of the balance or $1.50, whichever is greater, will be charged on all unpaid balances. Payment is expected at the time of service. A processing fee will be charged on all checks returned unpaid. I authorize release of my medical information and payment of benefits to the physicians and/or GYFT Clinic on all covered services if billed to insurance. By my signature below I hereby authorize and consent to medical treatment by the physicians and/or medical staff of GYFT Clinic, PLLC. A photocopy of this authorization shall be considered valid as original.

Patient Signature: ____________ Date Signed: ____________