Print Form

HANNIBAL CLINIC OPERATIONS, LLC
PO BOX 311 HANNIBAL, MO 63401
573-221-5250

Account #

Patient Name: . . Today's Date:

Home Address: County:
City, State, Zip: , ,
Home Phone #: Cell Phone #:_____ Preferred Contact: ☐ Home ☐ Cell
Birthdate: SS#: Sex: Marital Status:

Employer: Phone #:
Employer Address:
City, State, Zip:

Email Address:_____ May we send you health related info: Yes / No

Referral Source: ☐ Newspaper ☐ Radio ☐ TV ☐ Friend ☐ Other _____

Primary Insurance name:
Group # ID# Policy Holder:
(If different than pt, please fill out section below)

Spouse/Parent/Legal Guardian Name: _____
Date of Birth: _____ SSN: _____
Address: _____ Phone #: _____

Secondary Insurance name:
Group # ID# Policy Holder:

Spouse/Parent/Legal Guardian Name: _____
Date of Birth: _____ SSN: _____
Address: _____ Phone #: _____

In case of emergency, contact (someone residing outside the home):
Relationship: Home Phone:

Is this visit a result of a work related injury: _____ YES _____ NO
If so, name of contact person: _____
Phone Number: _____

*** FOR OFFICE USE ONLY: Company official who authorizes treatment: _____

The Hannibal Clinic Operations, LLC, is hereby authorized to render medical treatment and other related services to the undersigned and the undersigned's spouse and minor children (if any) as presently or hereafter needed. In consideration thereof, the undersigned agrees to pay for such treatment and services, as well as for any treatment or services rendered for such persons prior to the signing hereof which are now unpaid, whether barred by the statue of limitations for not, all as one running account.

I understand that payment in full is due upon the rendering of treatment of services. If the account becomes delinquent and is referred to a collection agency for collection, the undersigned agrees to also pay all collection fees and expenses. If the account is forwarded to an attorney, the undersigned agrees to also pay all attorney's fees and expenses. If a suit is filed to enforce collection, the undersigned agrees that it may be filed in a court in Hannibal, Marion County Missouri, where the main Hannibal Clinic Operations, LLC office is located.

I authorize payment to the Hannibal Clinic Operations, LLC, for medical benefits or services rendered, and I authorize the Hannibal Clinic Operations and its physicians, employees and agents to release medical information to insurance companies, third party payors, Healthcare Financing Administration and its agents as is necessary for completion of insurance claims, determination of benefits and related items.

I certify that the information given by me in applying for payment under Title (18) XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Medicare Program and/or the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. This authorization and request shall apply to the period _____ to _____.

Patient Signature: _____ **Spouse Signature:** _____ **Date:** _____