GEORGE KRAMER, M.D.
Advanced Medicine
ALTERNATIVES

11500 Hwy 7, Suite 206
Minnetonka, MN 55305
952.767.4800 • info@georgekramermd.com
georgekramermd.com

PATIENT INFORMATION

Name: _____ DOB: _____ Marital Status: S M W D
Last First M.I.

A**re you currently covered under Medicare? N Y** If yes, you will need to sign a Private Contract.

Address:_____ Phone Home: ( )_____
Street / Apt. #
Work: ( )_____
_____ _____ _____
City State Zip Cell: ( )_____

E-Mail Address: _____

Spouse's name:_____ Work phone: ( )_____

Responsible Party (if different from above): _____ Phone: ( )_____

Address: _____ Work Phone: ( )_____

Occupation: _____ Employer: _____

Relationship: _____

Who should we contact in case of emergency? _____ Phone: ( )_____

Primary Care Doctor: _____ Phone: ( )_____

Name of Clinic:_____

Address: _____
Street City State Zip

ACKNOWLEDGEMENT: By signing below, you are acknowledging and agree to the following:

a. I certify that the above information is true correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

b. Dr. George Kramer does not participate in health plans or Medicare. Payment for the visit is expected at the time of service. For convenience, payment by cash, check, American Express, VISA, Mastercard or Discover is accepted. I will be given a receipt containing the necessary information needed to file a claim as some insurance companies (other than Medicare) may provide reimbursement. Therefore, I acknowledge and agree that I am ultimately responsible for the balance of my account regardless of whether any reimbursement is received or not.

c. If I am covered under Medicare, I understand that under the provisions of the Private Contract, I may not submit or attempt to obtain any reimbursement from Medicare for the services provided by Dr. George Kramer.

d. I hereby authorize George Kramer, M.D. to examine and treat my (or the patient's) condition as he deems appropriate.

e. I hereby request and authorize George Kramer, M.D. to release medical information about me to my referring / primary care physician(s) and insurance company if requested:

_____
Referring Physician - Name Clinic Name Specialty

_____
Street Address City State Zip

Signed: _____ Date: _____
(If person signing is not patient – please state relationship.)