ADVANCED MEDICINE ALTERNATIVES, LTD.

Today's Date: _____

Patient Information

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

Are 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: _____

How did you learn about our office /or who referred you? _____

Employer: _____ Occupation: _____

Spouse's name: _____ Work phone: ( )_____
Nearest Friend / Relative
Not living with you: _____ 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 check, 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.)