



HEALTH MANAGEMENT CONSULTANTS II, P.C. DBA

Redi Care South

Patient

Name: _____
(last) (first) (middle initial)

Sex: Male/Female Date of Birth: _____ Age: _____

Address: _____
(street) (city) (state) (zip)

Home Phone: _____ Cell Phone: _____

Email Address: _____

Employer Name: _____ Employer Phone: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact Name and Phone #: _____

Records Release facilities or individuals

Name and Phone # _____ relationship _____

Name and Phone # _____ relationship _____

I understand that this permission may be revoked by me at anytime

Patient SSN/ Claim # _____ Responsible payee _____

1st Insurance Carrier _____ Contract # _____

Group # _____

Subscriber

Name _____ DOB _____ SSN _____

I request that payment of authorized Medicare/other insurance carrier benefits be made on my behalf to Redi Care South for any services furnished to me by this provider. I authorize any holder of medical or other information about me to release to my insurance carrier and its agents any information needed to determine these benefits for related services. I am responsible for the total bill; regardless of the amount my insurance carrier pays. I also understand that I have given permission to the listed facilities or individuals to obtain pertinent medical information.

Responsible Party Signature: _____ Date: _____