CBMD

CHRISTOPHER BARLEY, M.D.

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PATIENT INTAKE FORM

PERSONAL INFORMATION:

Name: _____ **Referred By:** _____

Address: _____ **Date of Birth:** _____

City: _____ **SS#:** _____

State/Zip: _____ **Landline/Home:** _____

Email: _____ **Cell Phone:** _____

Ethnicity: _____ **Work Phone:** _____

EMERGENCY CONTACT INFORMATION:

Name: _____ **Relationship:** _____

Cell Phone: _____ **Work Phone:** _____

PHARMACY INFORMATION:

Name: _____ **Address:** _____

Phone Number: _____

INSURANCE INFORMATION:

Insurance Company: _____

ID#: _____ **Group#:** _____

Insured Name: _____ **Relationship:** _____

I understand that Christopher L. Barley, M.D. does not participate with any insurance plans and payment is expected at the time of service. I authorize any holder of medical or other information about me to release to my insurance carrier any information needed for this or a related medical claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits be paid to myself.

I understand that 24 hours notice is required prior to cancelling an appointment. **Same day cancellations <u>may result</u> in a partial visit charge. Also, I understand that additional charges m<u>ay occur</u> for record reviews, lengthy telephone consults, emails and coordination of medical records, copies of records, completion of forms, prescription refills, referrals, and prior authorizations that are required by insurance companies for prescriptions, referrals and testing. Our Practice E-Prescribes and therefore we will be reviewing your past Medication History**

Signature: _____ **Date:** _____