Karina von Middendorf Ph.D.

SF Office
50 California St. Ste 1500
San Francisco, CA 94111

CA Lic# MFC38189
(415) 408-8801
drvonmiddendorf@att.net

Marin Office
1050 Bridgeway
Sausalito, CA 94965

PATIENT INFORMATION and FINANCIAL AGREEMENT

PLEASE PRINT CLEARLY—*Required Information

*Name (Last, First, M. I.) ____________________

*Address ____________________ Email: ____________________

*City, State, Zip Code ____________________

*Home Phone ____________ Work Phone ____________ Other ____________

*Social Security # ______--______--______ *Date of Birth ______/______/______ *Sex: F M (circle one)

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Retired

*Employer ____________________ Position ____________________

Address ____________________ Phone ____________________

PRIMARY INSURANCE (COPY ALL INFORMATION EXACTLY AS IT APPEARS ON YOUR CARD):

*INSURANCE COMPANY ____________________ Employer ____________________

*Policy Holder's Name (leave blank if same as above) ____________________

*Policy/ID# Number ____________________ * Group Number ____________ *Co-pay $__________

*Claims Address ____________________ *City, State, Zip ____________________

*Phone ____________________ *Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

*DOB______/______/________ * SS# _______--_______--______ (For verification purposes only) Auth# ____________

*OTHER INSURANCE ____________________ ID# ____________________

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Person to Contact in case of Emergency

Name ____________________ Relation ____________ Phone ____________________

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CREDIT CARD INFORMATION (REQUIRED): In the event your account becomes more than 30 days past due, I authorize Karina von Middendorf to debit my account for any unpaid fees that are considered my financial responsibility. Please print clearly and sign your authorization and agreement below.

CARD TYPE: VISA M/C DISCVR AMEX

Card#____________________ **Exp. Date**____________ **3-dig code** __________

Name as it appears on Card:____________________

Signature:____________________ **Date:**____________________

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FINANCIAL RESPONSIBILITY & RELEASE OF INFORMATION AGREEMENT (SIGNTURE REQUIRED)

By signing below, I agree to the following policies of Dr. Karina von Middendorf's practice and services she provides:

1) I authorize use of this form or a copy of it to convey my personal and insurance information to House Medical Billing Service.
2) I authorize release of information to my insurance company for claims billing purposes.
3) I authorize insurance payments directly to the provider.
4) I understand I am responsible for the full amount of my bill for services provided. Cash, Check, Credit Card & PayPal are accepted.
5) **There is a 48-hour cancellation policy. I understand I will be billed *immediately* for the cash rate of $125 if I do not cancel at least 48 hours in advance of my appointment time.**
6) I authorize any past due balances for services, copays or deductibles applied by insurance to be billed to my credit card if they become more than 45 days past due.
7) In the event that my account goes unpaid for more than 90 days I acknowledge it may go to collections and I will be responsible for the balance due plus a 30% collection fee.
8) Payment for services is ultimately my responsibility as insurance cannot be guaranteed.

I agree to these terms:

SIGNATURE OF RESPONSIBLE PARTY____________________ **DATE:**____________

Name (Printed)____________________ **Relation to Patient**____________________

PLEASE RETURN THIS COMPLETED FORM TO VICTORIA; Fax (866) 849-0672 or vhouse@housebilling.com