BioMD Balance SOLUTIONS

# INTAKE INFORMATION

| | | |
|---|---|---|
| **Your Name:** | Last: | First: |
| **Date of Birth / SS#:** | DOB: | SS#: |
| **Address:** | Address: | City: |
| | Apt/Ste.: | State/Zip: |
| **Personal Phone / Cell:** | Home: | Cell: |
| **Work Phone / Fax:** | Office: | Fax: |
| ****Important**** ***Your E-mail address*****:** | | Alt: |
| **Who referred you?** | | Phone: |
| **Insurance Company:** | | Internal Code: |
| **Address:** | | City / Zip: |
| **Phones:** | | Fax: |
| **Policy Holder?** | | ID#: |
| **Credit Card Number:** | | Exp Date: |

***Please note:*** We are not contracted with any insurance companies, nor do we submit any claim forms.

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I authorize and consent to the administration of all diagnosed and therapeutic treatments that may be considered by Olga Beregovskaya, MD, as medially indicted or necessary based upon prior discussion.  I am aware that I have the final say in all aspects of my medical management by Dr. Olga Beregovskaya and/or her associates, representatives and appropriate office staff.

_________________________And dated this,________________________2015

I authorize the office of Olga Beregovskaya, M.D. to charge to my listed credit card fees for services, supplies or missed appointments that I have requested, received or failed to cancel within 24 hours of my appointment.  I will be notified of all charges placed on my credit card and will be sent a receipt documenting said charges.  This arrangement shall stay in effect unless revoked by written request and/or on an annual basis (calendar year).

_________________________And dated this,________________________2015

***Office staff:*** please attach a copy of the patient's insurance card and a copy of their Driver License or other photo ID to the back of this form.