NEW INDIVIDUAL INFORMATION SHEET

Name: _____ Diagnosis: 1) _____

Agency: _____ 2) _____

Site: _____ 3) _____

Date of Birth: _____ Gender: _____ 4) _____

Social Security #: _____ 5) _____

Allergies: _____ Other: _____

_____

Diet: _____ _____

Billing Information **[Please provide a photocopy of all insurance cards used for prescriptions]**

Primary Insurance: _____ Secondary Insurance: _____

I.D. #: _____ Seq #: _____ I.D. #: _____ Seq #: _____

Group #: _____ Plan #: _____ Group #: _____ Plan #: _____

Medicaid #: _____ Medicaid Seq#: _____

Medicare Part A Effective Date _____ Medicare Part B Effective Date: _____

Medicare #: _____

I agree that I am responsible for any charges for Prescription Medications, Over the Counter Medications, supplies or other items provided by Parkview related to my care which are not covered by a third party insurance. I understand that Parkview will send a monthly invoice to my attention or the designee below. I agree to maintain a Parkview A/R account at all times during my care.

Individual/ Guarantor _____
(Print Name)

Phone: _____

Billing Address: _____

_____

_____

Signature: _____ Date: _____

FAX FORM TO: 716-876-1349 or TOLL FREE 888-690-5250