DR JOEL P KARASEK MD PC
3955 SHERMAN AVENUE ST. JOSEPH, MO 64506

PLEASE COMPLETE ENTIRE FORM AND PRINT CLEARLY TODAYS DATE:_______________

Patient's Name(s): ______________________________DOB:__________________Male___Female_____

______________________________DOB:__________________Male___Female_____

Address:__________________________________City:_________________State:_______Zip:__________

Home Phone:____________________________ Cell Phone:_____________________________

Parent or Legal Guardian:
Name:____Birth date:________ Relationship:________

Address:__________________________________City:__________________State:_______Zip:________

SSN:_______________________________ Employer:________________ Work Phone:______________

Other Parent or Legal Guardian:
Name:____Birth date:_________Relationship:________

Address:___________________________________City:_________________State:_______Zip:________

SSN:_______________________________ Employer:________________ Work Phone:_______________

Insurance Information: A copy of your insurance card must be on file to submit to Insurance

Primary Ins:____________________________Subscriber's Name:________________________________

Subscribers DOB:__________________Policy #___________________Group#____________________

Secondary Ins:__________________________Subscriber's Name:_________________________________

Subscribers DOB:__________________Policy #___________________Group#_____________________

Consent to Treat

I understand it is policy of this clinic to have a parent or legal guardian present when patients under the age of 16 are examined or treated. If I am unable to bring my child, I understand I must have written authorization to treat sent with the adult that brings my child, or have one of the individuals listed below bring the child in. I consent to have the above named patient(s) evaluated and treated. I also consent to allowing the authorized person(s) listed below to obtain treatment of my child.

Signature of guardian:____

Persons listed are authorized to bring in my child for evaluation & treatment:
1:_______________ __________________________ Relationship:____

2:____ Relationship:____

Emergency Contact (other than parents)
Name:____Relationship:___________________Phone:_________________________

Financial Responsibility/Release Information

I hereby give authorization to file claims and assign insurance payments directly to Dr Joel P Karasek M.D. P.C. for services rendered. I understand I am financially responsible for charges not covered by my insurance. But not limited to medical services deemed routine, or not medically necessary by my insurance company. Co-pays, deductibles, co-insurance amounts or non-covered items are my responsibility as well as outstanding charges the insurance has not paid in a timely manner. I hereby authorize release of information acquired in the course of examination and treatment to my insurance company or other necessary medical person assisting in care. **I agree to pay any collection fees, attorney fees, or court cost assessed in the event my account is placed with an outside agency for collection.** This authorization is considered valid until revoked by me in writing.

X____ Date:______________________________