



Richard E, Fine, MD
 Cynthia Matthews, MSN, CNP
 Deidra Sikorski, MSN, FNP-C
 790 Church Street, Suite 410
 Marietta, GA 30060
 Phone: 770-422-1988, Fax: 770-422-1036

PATIENT INFORMATION

Last Name		Suffix	First Name		Middle Initial
SS #		Street Address			
City	State	Zip	Birth Date	Male or Female	Marital Status
Home Phone		Work Phone		Cell Phone	
Employer Name and Address			Email		
Primary Care Physician (name and phone number)			Obstetrician/Gynecologist (name and phone number)		
Relative/Friend not living with you		Relative/Friend Phone #		Relationship	

Insurance Policy Holder (Sponsor's Information, leave blank if same as above)

Last Name		Suffix	First Name		Middle Initial
SS #		Street Address			
City	State	Zip	Birth Date	Relationship to insured	
Home Phone		Work Phone		Cell Phone	
Employer Name and Address					

Insurance Information

Primary Insurance Company	Policy Number	Group Number
Secondary Insurance Company	Policy Number	Group Number

When checking in, the receptionist will need any insurance cards that you have and your driver's license.

We will file insurance with your provider according to your individual plan. The patient is responsible for any outstanding deductible, co-insurance, and/or co-pay. Referral numbers required by some insurance companies must be received at the time of service; otherwise, the service becomes the patient's responsibility. For all private insurance companies, the patient will be responsible for payment at the time of service. We will provide the necessary information for the patient to file for reimbursement.

Our fees for surgical procedures will vary depending on the complexity of your problem and the service provided. If a surgical procedure is performed outside of our facility, we will gladly assist you in pre-certification and second opinions. You will receive separate bills from the surgery facility, lab, etc.

Advanced Breast Care shares your concern about increasing costs of quality health care. Asking for payment at the time of service rendered helps us to lessen our expenses and keep cost down. We will be glad to discuss our fees with you at any time. A cost estimate may be given in advance whenever requested.

If payment of charges imposes a financial burden, we ask that you speak to the office manager for specific payment arrangements. We will make every effort to assist you with your needs.

Authorization to pay benefits to physician. I hereby authorize payment directly to the physician of the surgical and/or medical benefits, if any, otherwise payable to me for her services as described realizing that I am responsible to pay non-covered services	Patient's Signature and Date
Authorization to release information: I hereby authorize the physician to release any information required in the course of my treatment necessary to process insurance claims.	Patient's Signature and Date

For office use only

Date of service: _____ Staff Initials: _____ Entered: _____ Scanned: