Visiting Patient Registration 2020

Lori McAuliffe, M.D., P.A.
405 Pasadena Ave S, St. Pete, FL 33707

Patient Name: _____ **Referred by:** _____
Date of Birth: _____
Home Address: _____
_____

Preferred Phone #: _____

E-Mail Address: _____

Insurance Information

Primary Insurance Name: _____ Effective Date: _____
Policy Holder's Name: _____ Claims PO Box: _____
Policy Holder's Date of Birth: _____
ID or Policy #: _____ Group #: _____

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical insurance status. I certify that my child has health insurance currently in force as detailed above. I assign directly to Lori McAuliffe, M.D., P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I, the undersigned, agree to be financially responsible:

_____ _____
Signature of Patient **Date**

_____ _____
Witness Signature: Date

Office Use Only:
Received: ____ Credit Card Information
Accepted by: ____ C.L. ____ C.Z. ____ E.T. ____ P.N. ____ L.I. ____ T.M. ___ A.C. ____ K.M.