

# Lemire Clinic

JAMES E. LEMIRE, MD, PA  
Natural family medicine with a personal touch

## Patient Release Form

Please Print Clearly

Patient First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Social Security Number \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex  Male  Female  
Marital Status:  Single  Married  Divorced  Separated  
Patient Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Alternate Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other Phone \_\_\_\_\_  
E-mail \_\_\_\_\_ We will **NEVER** give your email address to anyone.  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
How were you referred to our office? \_\_\_\_\_

Type of medical insurance:  Commercial Insurance  Medicare  Medicaid  None

Primary Insured Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Phone \_\_\_\_\_  
Primary Insured's Social Security Number \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_ Primary Insured's Employer \_\_\_\_\_  
Medicare Beneficiary \_\_\_\_\_ Medicare # \_\_\_\_\_  
Commercial Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

**By signing below, I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to the doctor indicated on the claim.**

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO LEMIRE CLINIC, JAMES E. LEMIRE, MD, PA FOR ANY SERVICES FURNISHED TO ME BY THAT FACILITY. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER. I ALSO UNDERSTAND THAT CHARGES FOR ANY SERVICE NOT COVERED BY MY INSURANCE ARE DUE AT THE TIME OF SERVICE.

KINDLY GIVE 24 HOUR NOTICE IF YOU ARE NOT ABLE TO KEEP YOUR SCHEDULED APPOINTMENT TO AVOID A \$45.00 FEE.

I ALSO UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THE STAFF OF WHICH LABORATORY (BLOODWORK) AND DIAGNOSTIC CENTER (X-RAYS, ETC.) MY INSURANCE COMPANY WILL ALLOW ME TO USE.

I HEREBY STATE THAT THE INFORMATION GIVEN ABOVE IS CORRECT. IF I AM UNDER THE AGE OF 18 MY PARENTS OR LEGAL GUARDIAN WILL SIGN.

Signed

\_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**IN CASE OF MINOR OR GUARDIANSHIP:** Person responsible for bills if different than Patient.

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
D.O.B. \_\_\_\_\_ S.S. # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_