Access HEALTH
2020 Hospital Drive, Suite 1
P.O. Box 338
Windom, MN 56101
507-831-1703

Patient Payment Information

Please fill out completely or we will not be able to file your insurance.

Patient Information

Name (last)_____ First_____ MI_____
Address_____ City_____ State_____ Zip _____
Date of Birth_____ Sex ❑ M ❑ F SS# _____
Occupation_____ Employer_____
Phone (home)_____ (work)_____ Marital Status ❑ S ❑ M ❑ D ❑ W
Notify in case of emergency:_____ Phone:_____
Children: Name _____ M F BD _____
Name _____ M F BD _____
Name _____ M F BD _____
Name _____ M F BD _____
Name _____ M F BD _____

Party Responsible for Payment (if different than patient information)

Name (last)_____ First_____ MI_____
Address_____ City_____ State_____ Zip _____
Date of Birth_____ Sex ❑ M ❑ F SS# _____
Occupation_____ Employer_____
Phone (home)_____ (work)_____ Marital Status ❑ S ❑ M ❑ D ❑ W

Insurance

(1) Name of Insurance Company _____ ID # _____
Address _____ Group # _____
Subscriber _____ Date of Birth_____
Subscriber's Employer _____
Patient Relationship to Subscriber _____
Subscriber's SS #:_____ Subscriber's Sex: ❑ M ❑ F

(2) Name of Secondary Insurance Company _____ ID # _____
Address _____ Group # _____
Subscriber _____ Date of Birth_____
Patient's Relationship to Subscriber_____

I request payment of authorized benefits be made on my behalf to Access Health for any services furnished me by Access Health. I authorize my holder of medical information to release insurance carriers any information needed to determine benefits payable for services provided. I understand that I am responsible for any amount not covered by insurance.

Time:_____ Date:_____ Patient Signature: _____