DAWN L. SHOGREN, M.D., P.A. 5485 BELT LINE ROAD, SUITE 160 DALLAS, TEXAS 75254
PHONE 972-392-2882 FAX 972-392-4407

Patient Name _____
Date of Birth _____/_____/_____ Age _____
Address _____
City, State, Zip _____
Home Phone _____
Cell Phone _____ Work Phone _____
Patient Email: _____@_____
SS# _____ Marital Status _____
Sex _____

Employer or School
_____
Address _____
City, State, Zip _____

Spouse's Name _____
Date of Birth_____/_____/_____ Cell Phone _____
Spouse's Employer _____

IF PATIENT IS UNDER 18 OR RESIDING WITH PARENTS, PLEASE COMPLETE:
Mother's Name _____
Cell Phone _____
Employer _____ Work Phone_____
Date of Birth _____ SS# _____
Father's Name _____
Cell Phone _____
Employer _____ Work Phone _____
Date of Birth _____ SS# _____
If parent's address is different from patient, please list:
_____

IN CASE OF AN EMERGENCY, PLEASE CONTACT:
Name _____ Cell Phone _____
Home Phone _____
Address _____
City, State, Zip _____
Relationship _____
How did you hear about Dr. Shogren? _____
May we contact that person? _____
Please list any children/age:
_____
Please list the name of all insurance companies that you are filing with for these visits:
_____
_____

DAWN L. SHOGREN, M.D., P.A.

FINANCIAL POLICY

PAYMENT IS EXPECTED AT THE TIME OF SERVICE, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

REGARDING INSURANCE – IN NETWORK

As a courtesy, we will be glad to assist you in filing your insurance. The following Assignment of Benefits and Release of Information Authorization must be signed for this office to file insurance claims on your behalf.

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of benefits to Dawn L. Shogren, M.D. for services rendered by her. I understand that I am financially responsible for any balance not covered by insurance.

SIGNATURE _____ DATE _____

REGARDING INSURANCE – OUT OF NETWORK

As a courtesy, we will file your out of network insurance, as unassigned. This means payment will come directly to you based on your out of network benefits. Payment is expected at the time of service unless prior arrangements have been made.

SIGNATURE _____ DATE_____

RELEASE OF INFORMATION AUTHORIZATION

I authorize the release of my medical or other information to my insurance company, which is necessary to process a claim.

SIGNATURE _____ DATE_____

UCR (USUAL AND CUSTOMARY RATES)

My practice is committed to providing the best treatment possible for my patients, and my charge is based on what is usual and customary in this area. You are responsible for payment in full, regardless of any insurance company's arbitrary determination of usual and customary rates. For those patients with managed health care, for whom I am a provider, you will be responsible for the amount determined by your plan. If I am an out-of-network provider for your plan, you will be responsible for my UCR rate. Initials: _____

INSURANCE DISCLAIMER

Every effort is made to be sure that the benefit information given to you is accurate. If a conflict exists between the information provided to you and the terms of the plan, the terms of the plan govern. Final determination of coverage and patient responsibility is made at the time your claim is received and processed by your insurance company. Initials: _____

ADDITIONAL FEES

Prescription refills are given at the time of the appointment. Any interim refills are subject to the following: Controlled substances are subject to **$50** fee per interim refill. Other routine medications are subject to a **$25** fee per interim refill. Initials: _____

There will be a fee for a completion of paperwork/forms beyond the usual scope of practice. This includes, but is not limited to: FMLA Paperwork, Life Insurance, Disability, Affidavits and Extensive Records Record Requests. These fees are based on the amount of time it takes for completion by the doctor.

SIGNATURE _____DATE_____

MISSED APPOINTMENTS/LATE CANCELATIONS *(PLEASE READ CAREFULLY)*

Unless canceled **48 hours in advance**, my policy is to charge for missed or late canceled appointments at the rate of $280.(The standard rate for an office visit). Insurance companies do not reimburse for missed or late canceled appointments. Help me serve you better by keeping scheduled appointments.

If you have any questions or concerns regarding this Financial Policy, please discuss it with me or my office manager.

I have read the Financial Policy. I understand and agree to this Financial Policy.

SIGNATURE _____ DATE_____

CREDIT CARD AUTHORIZATION

I authorize Dawn L. Shogren, M.D. to charge my credit card for any missed appointments or appointments canceled less than 48 hours prior to the appointment time, at the rate of $280.

I further authorize Dawn L. Shogren, M.D. to charge my credit card for any unpaid balance on my account that is beyond 45 days past due.

The credit card to be used is:
VISA/MASTERCARD _____ _____ _____ _____

EXPIRATION DATE _____

CVV_____

BILLING ZIP_____

SIGNATURE _____ DATE _____