MED CENTRAL HEALTH RESOURCES, INC.
3424 CLEMSON BLVD, ANDERSON, SC 29621
864-261-3022 FAX 864-224-5990

Name: _____
Last First Middle

Mailing Address: _____

Street Address if different: _____

Gender: ____F _____M Social Security #: _____ DOB: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

If your account is in default your cell number will be used in the collections process

Employer: _____Phone #: _____

Primary Insurance: _____ Secondary Insurance: _____

Primary Insured: _____ DOB: _____ SS#: _____

Emergency Contact (Does not live in the home): _____

Emergency Contact Phone Number: _____ Relationship: _____

I authorize the release of any information necessary to process my insurance claim _____ Initial

I authorize payment of benefits to Med Central Health Resources, Inc. for medical services _____ Initial

I understand that I am responsible for payment of services for which my insurance company or employer does not pay (according to contractual arrangement with the insurance company). _____ Initial

We file all insurance plans. If we are not in your network, out of network benefits apply. Check with receptionist before being seen to see if we are in your network. **PAYMENT IS EXPECTED AT TIME OF SERVICE**

I HAVE CORRECTLY COMPLETED THIS FORM AND UNDERSTAND THE PAYMENT POLICY

Signed: _____ Date: _____