

DONNA NIKANDER MSN, FNP

Patient Information	
Name _____	Home Phone No. () _____
Address _____	Work Phone No. () _____
City _____ State _____ Zip _____	Email Address _____
Gender: FEMALE MALE	Emergency Contact _____
Employer _____	Date of Birth _____
_____	SSN _____
_____	Marital Status: Single Married Other
Name of Referring Provider _____	Is this visit injury related: YES NO
Referring Provider Phone No. _____	Date of Injury _____
Address _____	Workers Comp Injury: YES NO
_____	If YES, Employer Name _____
_____	Auto Injury: YES NO If YES, what State _____
_____	Is your case in litigation? YES NO
_____	If YES, Attorney's Name/Phone No. _____
_____	_____

Insured Party Information	
Name _____	Home Phone No. () _____
Address _____	Employer _____
City _____ State _____ Zip _____	SSN _____ DOB _____
_____	Relationship to Patient: Self Wife Husband Child

Insurance Information	
Insurance Co Name _____	Subscriber # _____
Claims Address _____	Group # _____
City _____ State _____ Zip _____	Phone () _____
Adjusters Name/Phone _____	Auto/Work Comp Claim # _____
_____	_____

I authorize the release of any medical information necessary to process this claim.

I, the undersigned agree, whether signing as agent, or patient, that is consideration of the services rendered to the patient, to be individually obligated to pay the bill. Should the account be referred to an attorney for collection, I shall pay reasonable attorneys fees.

I hereby assign payment directly to Donna Nikander MSN, FNP, BASIC BENEFITS and/or MAJOR MEDICAL (catastrophe) BENEFITS herein specified and otherwise payable to me but not to exceed the regular charges for this period of treatment. I understand I am financially responsible for any charges not covered by this assignment.

I understand that upon discharge I may request, in writing, a copy of my records, I have read, understand and signed the Donna Nikander MSN, FNP Financial Policy.

Signed _____ (Parent or Guardian if minor or dependent) Date _____

Consent for Treatment
 I hereby consent to such treatment procedures and patient care which may be necessary or advisable while a patient of Donna Nikander

Signed _____ (Parent or Guardian if minor or dependent) Date _____