

**FOCUS CENTERS OF ASHEVILLE, PLLC**

**Phillip Ellis, Ph.D.**

417 Biltmore Ave., Ste. 4-B Asheville, NC 28801  
828-281-2299

Please fill in **ALL** blanks

Date: \_\_\_\_\_

**New Patient Information**

Please **PRINT**

**Patient Name:** \_\_\_\_\_  
Last First Middle Initial

Male  Female

Mailing Address: \_\_\_\_\_

\_\_\_\_\_, \_\_\_\_\_ Zip \_\_\_\_\_ Parent/Adult Email Address: \_\_\_\_\_

Home Phone : \_\_\_\_\_ Birthday: \_\_\_\_\_ Social Security # \_\_\_\_\_;

Married  Single  Widowed  Divorced  Other: \_\_\_\_\_ Age \_\_\_\_\_

**How did you hear about us:** \_\_\_\_\_

**Reason for visit:** \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_  
Last name first Initial

**INSURANCE:**

Company: \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
city state zip

Phone # \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Name of Insured: \_\_\_\_\_ Birthday \_\_\_\_\_ SS # of insured \_\_\_\_\_

Address if different: \_\_\_\_\_  
City state zip

**SECONDARY INSURANCE:**

Company: \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
city state zip

Phone # \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Name of Insured: \_\_\_\_\_ Birthday \_\_\_\_\_ SS # of insured \_\_\_\_\_

Address if different: \_\_\_\_\_  
City state zip

**MEDICARE PATIENTS:** Phillip Ellis, Ph.D., is a Medicare provider and will file your claim. As a Medicare patient, you will be responsible, by law, for your yearly deductible and the 20% (co-insurance) due after the Medicare payment has been paid to us. If you have a secondary insurance, we will file only if your company is a Medigap crossover. In the event your insurance company is not a Medigap member, we will be unable to file to the secondary insurance company. If, after 45 days, the Medigap crossover claim is not paid, or if you do not have a secondary insurance coverage policy, you will be responsible for the remaining balance. Should you have any questions as to whether your secondary insurance company is a Medigap crossover company, please feel free to inquire with our office management.

**SIGNATURE:** \_\_\_\_\_ **Date** \_\_\_\_\_

**INSURANCE PATIENTS:** Phillip Ellis, Ph.D., provider, will file your claim to your primary carrier, with the information you provide. You will be responsible for your yearly deductible, copay, co-insurance and other fees not covered by your insurance. If, after 45 days, your claim is not paid, or if you do not have an insurance coverage policy, you will be responsible for the remaining balance.

**SIGNATURE:** \_\_\_\_\_ **Date** \_\_\_\_\_

**REASSIGNMENT OF BENEFITS:** I authorize, Phillip Ellis, Ph.D., or any holder of medical information to release any information, original or copies, needed to pay/process a claim I may file. I Hereby authorize payment to Phillip Ellis, PhD benefits specified and otherwise payable to me for any services rendered subsequent to this date and for such other charges as may be made by his office. I agree to pay for charges not covered/denied by my insurance.

**SIGNATURE** \_\_\_\_\_ **Date** \_\_\_\_\_

**AUTHORIZATION / PRE-CERTIFICATION:** does your insurance require ?  Yes  No

If yes, authorization or precert # \_\_\_\_\_