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: _____ ☐ Male ☐ Female
Last First Middle Initial

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 # _____

MediClaims Link is the patient account and billing firm that will process your claim. We respect the privacy of each patient and will hold patient information confidential. Please call if you have questions about your account 828.299.0054