TAMARA BROWN, MD, LLC
5835 CAMPBELLTON ROAD, SW, SUITE 201, ATLANTA, GA 30331

Last Name_____ **First Name**_____ **MI**____ **Male**___**Female**___

DOB_____/_____/_____ **SS#**_____ **Marital Status**_____

Address_____
(number, street, city, state, zip)

Home Ph#_____ **Alternate Ph#**_____**(cell/work- Circle one)**

Pharmacy_____ **Pharmacy Ph#**_____

Employer_____ **Work Ph#**_____

Employer's Address_____
(number, street, city, state, zip)

Emergency Contact_____ **Ph#**_____ **Relationship**_____

Closest Relative Not Living With You_____ **Ph#**_____ Relationship____

Insurance Information (Primary)

Company_____ **Address**_____

Policy Holder_____ **Relationship to Patient**_____ **DOB**_____

Policy Holder's SS#_____ **Insurance ID#**_____ **Group#**_____

Insurance Information (Secondary)

Company_____ **Address**_____

Policy Holder_____ **Relationship to Patient**_____ **DOB**_____

Policy Holder's SS#_____ **Insurance ID#**_____ **Group#**_____

*****************PLEASE READ CAREFULLY*****************

FINANCIAL POLICY, RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS. Payment for services is due at time of services rendered unless payment arrangements have been approved. Any and all co-payments are to be paid prior to seeing the provider. We will assist you in processing your insurance claim. Insurance coverage is a contract between you and your Insurance Company. You are ultimately responsible for paying this bill. BALANCES GREATER THAN 90 DAYS OLD WILL BE SUBJECT TO INTEREST CHARGES AT A RATE OF 1.5% PER MONTH. This interest is binding unless waived by the provider. I HEREBY AUTHORIZE AND DIRECT MY INSURANCE COMPANY (IES) TO MAKE PAYMENT TO TAMARA BROWN, MD, LLC FOR SERVICES RENDERED. IF PAYMENT IS NOT MADE BY THE INSURANCE COMPANY, I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. I HEREBY AUTHORIZE TAMARA BROWN, MD, LLC AND STAFF TO RELEASE ANY INFORMATION REQUIRED TO PROCESS ANY AND ALL MEDICAL CLAIMS. A photocopy of this agreement shall be considered as effective and valid as the original copy.

*******PLEASE NOTE THAT A $25.00 FEE WILL BE CHARGED FOR ALL APPOINTMENTS CANCELLED WITH LESS THAN 24 HOURS ADVANCE NOTICE. A FEE OF $50.00 WILL BE CHARGED FOR PHYSICAL APPOINTMENTS THAT ARE NOT CANCELLED AT LEAST 24 HOURS IN ADVANCE. *******

Signature_____ **Date**_____