JOVE MEDICAL, INC.

PLEASE PRINT CLEARLY & COMPLETE ALL ENTRIES

Patient Information:

Patient Name:		Social Security #	/ /
Date of Birth:	/ / Age:	Gender:	___ F ___M
Street Address:		Marital Status:	___ S ___M ___ D ___W
City, State, Zip:		Employment Status:	___ FT ___ PT ___ N/A ___ Student
Home Phone:		Employer Name:	
Work Phone:		Employer Address:	
Cell Phone:		Emergency Contact:	Relationship:
E-Mail Address:		Emergency Phone:	

Insurance Information:

Health Insurance:		Ins. Co. Phone:	
Name of Insured:		Policy #:	
Relationship to Insured:		Group #:	

Spouse Information:

Name:		Social Security #:	
Date of Birth:		Occupation:	
Age:		Employer:	

How did you hear about Jove Medical? ___ Friend: _____ ___ Health Care Professional: _____
___ Internet ___ Newspaper ___ Direct Mail ___ Other: (please describe) _____

DISCLAIMER AND INFORMED CONSENT:
I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company when appropriate. Any amount authorized to be paid directly to this office will be credited to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services already rendered me will immediately be due and payable.

I understand that I will be evaluated and treated by Deborah Collins, Advanced Registered Nurse Practitioner (ARNP), owner of Jove Medical, and/or her associate(s). I also understand that Deborah Collins (and therefore Jove Medical) has a supervising physician available to her for immediate consultation: Pedro A. Sanchez, D.O., a family practice physician. Furthermore, I clearly understand that Deborah may have associates that conduct his/her practice here at Jove Medical as independent provider(s). The Associate(s) services and relationships with patients are independent (not an employee) of Jove Medical. Each provider is individually responsible for the care, treatment, and services he or she provides on behalf of the patient. I hereby request and authorize Deborah Collins, ARNP, and/or her associates, to perform any evaluation, examination, diagnostic testing, and treatment as deemed necessary.

Patient Signature	Date	Patient Name (PLEASE PRINT)
Witness Signature	Date	Witness Name (PLEASE PRINT)

If the patient is a minor, permission is hereby given by me to the health providers of this office and whomever they designate to treat the patient. I am the patient's legal guardian.

Guardian's Signature	Date	Guardian's Name (PLEASE PRINT)