Patient Information

Last Name		Social Security #
First Name MI		Gender: ☐ Female ☐ Male
Mailing Address		Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Minor
City		Date of Birth
State	ZIP	Home Phone
Email		Work Phone
Referring Provider		Cell Phone

Responsible Party

Last Name		Social Security#	
First Name MI		Gender: ☐ Female ☐ Male	Birth Date
Mailing Address		Relationship to Patient	
City	State	Cell Phone	
Home Phone		Work Phone	

Insurance Information

Primary Insurance Company		
Group#	Identification#	
Insured Name	DOB	Social Security#
Relation to Patient	Employer	
Secondary Insurance Company		
Group#	Identification#	
Insured Name	DOB	Social Security#
Relation to Patient	Employer	

Notice of Privacy Practices

I acknowledge that I was provided the opportunity to review the Real Time II, LLC notice of privacy practices.

Signature of Patient/Guarantor Date

Real Time II, LLC
Patient Financial Policy

Private Insurance

Private Insurance information must be presented at the time of service. Co-payment is expected at time of service.

We will bill both primary and secondary insurance as a courtesy to our patient's. We allow 45 days per insurance company to pay. After 45 days with one insurance company and 90 days with two insurance companies the balance will become the patient's responsibility. It is our experience that insurance companies do tend to delay payment of claims; in this case you are the best advocate to contact your insurance company, as the contract is between the two of you. Please be prepared to pay your balance should your insurance company delay payment.

Medicaid

Medicaid co-payments are due at the time of service. If you have applied for Medicaid and are pending approval, you will have 30 days to provide our office with the required documentation proving eligibility. If this information is not received within 30 days, your account will be considered a self-pay account and payment on account will be required.

Self Payment

Payment is due at the time of service. A 15% discount is offered if payment is made in full at the time of service. If payment cannot be made in full, payment arrangements need to be made at the time of service.

I have read and understand the above financial policy. I hereby assign all medical benefits to which I am entitled to Real Time II, LLC. A photocopy of this authorization is to be considered valid as the original. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize Real Time II LLC to release information officially acquired in the course of examination and treatment needed to secure the payment. If the account is referred to an attorney for collections, I understand I am responsible for attorney fees and collection expenses. I understand that in connection with collection procedures that Real Time II, LLC has the right to request, receive, and renew all credit information as provided by a licensed and duly operated credit bureau.

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Signature of Patient/Guarantor

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Patient Name (Please Print) **Date**