



**THE KLEIN
CENTER FOR
Holistic Medicine**

Joel B. Klein M.D., P.C.

Balanced therapies for ultimate health

Joel B. Klein M.D., P.C.

719.457.0330

620 South Cascade Avenue
Colorado Springs, CO 80903

Welcome to our office

PATIENT INFORMATION

Patient Name SS# Marital Status Date of Birth Age Sex

Street Address City State ZIP Home Phone

Patient or Parent's Employer Occupation Business Phone Extension

Employer's Street Address City State ZIP

Emergency Contact Address/City/State Phone Number

Spouse or Parent's Name SS# Date of Birth

Spouse or Parent's Employer Occupation Business Phone Extension

Employer's Street Address City State ZIP

Spouses Address (if different) City State ZIP Phone Number

Person Responsible for Payment OR Primary Insured Address/City/State Phone Number

SS# Date of Birth Relationship to Patient Employer/Business Phone

Secondary Insured Address/City/State Phone Number

SS# Date of Birth Relationship to Patient Employer/Business Phone

PLEASE READ: ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPIDITE INSURANCE CARRIER PAYMENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE BOOKKEEPER.

INSURANCE AUTHORIZATION/RELEASE AND ASSIGNMENT:

NAME OF POLICY HOLDER: _____

I authorize the release of any/all medical records/payment of Medicare/Other Insurance company benefits be made whether to me or on my behalf to Joel B. Klein, MD, PC for services furnished to me by that party who accepts assignment/physician. Regulations pertaining to Medicare Assignment of benefits apply. I authorize the holder of medical or other information about me to release the Social Security Administration and Health Care Financing Administration or its intermediacies or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used as the original. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for treatment (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

Signature _____ **Date** _____