Mirabile M.D.
BEAUTY, HEALTH & WELLNESS

4550 W 109th Street, Suite 130
Overland Park, KS 66211
913-541-9495

PATIENT INFORMATION

Date _____Legal Name _____ Maiden _____
First Middle Initial Last
Soc. Sec. _____ Age _____ DOB _____
Email _____ May we add you to our email marketing list? Yes ____ No _____
Address _____ City _____ State _____ Zip _____
Home Phone (__)_____ Work (___)_____ Ext ___ Cell (__)_____
Employer _____ Occupation_____
Address_____ City _____ State ___ Zip _____

Spouse/Parent _____ DOB _____ Marital Status ❑ S ❑ M ❑ D ❑ W
Soc. Sec. _____ Employer _____
Home Phone _____ Work Phone _____
Emergency Contact (other than spouse)_____ Work Phone _____
Relationship to Patient _____ Cell Phone _____
Address _____ City _____ State ___ Zip _____

How did you hear about us?_____ If our patient please list _____

INSURANCE INFORMATION

Insurance _____ Group No._____
Policy No. _____ Employee _____ DOB _____
Employer _____ Work Phone _____

I understand that James Mirabile, M.D., P.A. is a collaborative practice of physicians and nurse practitioners. I hereby give my consent for James Mirabile, M.D., P.A., designee to provide medical treatment to me encompassing diagnostic and therapeutic procedures.

I hereby certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical records or other information about me to release to the Social Security Administration, its intermediaries or other insurance carriers any information needed for any related Medicare or insurance claim. I request that payment of authorized benefits for services rendered to me or my dependent be made on my behalf and assign payment for services rendered by physicians or representatives of Mirabile M.D. to be made directly to James Mirabile, M.D., P.A.,DBA Mirabile M.D. I further understand if I have an HMO policy and accept responsibility for payment of services rendered to me by Mirabile M.D. when a referral is not obtained prior to services being rendered.

I hereby authorize James Mirabile, M.D., P.A. to submit claims to my insurance carrier or its intermediates for all services rendered by the physicians or representatives of Mirabile M.D. I understand and accept responsibility for timely payment of any benefits denied by my insurance company and/or deductibles, co-pays or out-of-pocket expenses assigned to me.

PLEASE NOTE – a $40 fee will be imposed for missed appointments unless we receive 24 hour notice - initial: ☐

_____ _____

Signature of Patient of Guardian **Date**