Patient Application

Provider Name _____ ❑ **Single** ❑ **Couple** ❑ **Family**

First Name _____(M/F) Spouse First Name _____ (M/F)

Last Name_____ Spouse Last Name _____

Date of Birth _____ Spouse Date of Birth _____

Phone: Primary (_____) _____(h/c/w) Spouse Primary (_____) _____(h/c/w)

Phone: Alternate (_____) _____(h/c/w) Spouse Alternate (_____) _____(h/c/w)

E-mail Address _____

Street Address _____

City, State, Zip Code _____

Dependent _____(M/F) Date of Birth _____

Dependent _____(M/F) Date of Birth _____

Notes to Billing Department:

The Program Services (as that is defined in the Provider Services Agreement) eligibility for HSA/FSA/HRA funds for payment is a tax issue, therefore, please consult with your accountant or tax advisor. With respect to HRA or FSA funds, it is the Patient's responsibility to secure Program Services eligibility approval from the benefits coordinator.

I agree to the terms and conditions set forth in and acknowledge receipt of a copy of the Provider Services Agreement. With the signature below I acknowledge that I am authorized to sign for all members listed above.

AUTHORIZED PATIENT SIGNATURE _____ Date _____

PROVIDER SIGNATURE _____ Date _____

PAYMENT

❑ Annual Payment _____ ❑ Semi-Annual Payment _____ ❑ Quarterly Payment _____

After initial payment, the payment schedule will begin on _____ based on your payment of choice.

❑ Check (Check #_____) ❑ Credit Card Payment (Please circle: Visa/MasterCard/Discover)

Cardholder Name:	
Billing Address:	Billing Zip Code:
Credit Card Number:	
Expiration Date:	Security Code:

I acknowledge receipt of a copy of this application and agree to the terms of the payment plan listed above. I further authorize Cypress to charge my credit card on behalf of Provider for the balance of the services fees owed to Provider and not paid and in accordance with the payment schedule selected.

AUTHORIZED PATIENT SIGNATURE _____ Date _____

HIPAA RELEASE

I authorize the release of financial records for this account to the following individual not represented above:

Name _____ Phone _____

AUTHORIZED PATIENT SIGNATURE _____ Date _____