Please Note: So that we may maintain the most up to date and accurate information on our patients, in addition to the face sheet presented to you at every visit, we will request that you review and update this form at least once a year.

Patient Information

Name: First_____MI_____Last_____
SS#_____DOB:_____ Sex: Male____Female____
Marital Status: Single Married Divorced Widowed Separated Life Partner
Race: White Black/African American Asian American Indian/Alaska Native Native Hawaiian/Pacific Islander declined
Ethnicity: Not Hispanic/Latino Hispanic/Latino Unknown Declined
Preferred Language: English_____Spanish_____Vietnamese_____Other_____
Do you have any communication difficulties/special needs? Hearing loss Interpreter Required Reading Difficulty Sight Impaired
Other: Yes No If yes please list:_____
Address: _____Apt#_____City_____St_____Zip_____
Phone: Home_____cell_____Work_____
E-mail_____ (Confidential Medical Information Will NOT Be E-mailed)
Best Contact Method: Home Cell Work E-Mail Mail
Employment Status: Full-Time Part-Time Unemployed Student Disabled Retired
Occupation:_____

Financially Responsible

Name: First_____MI_____Last_____
DOB: _____
Relationship: Spouse Parent Guardian Other (Please Specify):_____
Address:_____Apt#_____City_____St_____Zip_____
Phone: Home_____Cell_____Work_____
Email: _____ (Confidential Medical Information Will NOT Be E-mailed)
Employer: _____

Emergency Notification

[ ] Check box if same as Guarantor. If different, please complete information below.

Name: _____Relationship to Patient:_____
Phone: Home_____Cell_____Work_____

Referral Form

☐Friend/Family Member ☐ Insurance Company ☐ Walk-in ☐ Phone Book ☐ Direct Mail ☐ TV
☐ Radio ☐Coach ☐ Trainer ☐ Newspaper_____ ☐Magazine_____
☐Web Search ☐ Practice Website
☐Another Physician/Provider_____ ☐ Other_____

Patient Name: _____DOB_____

Please provide a copy of all Insurance cards and a Driver's License/Photo ID

You will be asked to present your insurance card(s) at each visit so that we can confirm that all information in our files remains current.

Insurance Information

Primary Insurance: _____ID_____Gp_____

Policy Holder Name: _____Relationship (circle one) Self Spouse Parent Other_____

SS# _____ Policy Holder's DOB: _____Employer: _____

Secondary Insurance: _____ID_____Gp_____

Policy Holder Name: _____Relationship (circle one) Self Spouse Parent Other_____

SS# _____ ____Policy Holder's DOB: _____Employer: _____

Privacy Practices

Our office, physicians and staff, are committed to securing the privacy of your health information. We are making available to you a copy of our Notice of Privacy Practices.

Signature: _____Date _____

Medication Refill Policy

Please contact your pharmacy for medication refills. Your pharmacy will fax us a medication refill request which the physician will review. Refill authorizations required 48-72 hours. Please allow sufficient time for us to process your refill request.

Initial _____

Cancellation/No Show Policy

A 24 hour cancellation notice is required when a patient is unable to keep an appointment. Last minute cancellations, as well as no-shows prevent and/or delays other patients from accessing medical treatment. While we understand that unusual circumstances may force a patient to cancel their appointment last minute, those patients who demonstrate a pattern of behavior (3 no shows or cancellations) will be charged a $25 fee for each missed visit and/or will be dismissed from our practice. Please acknowledge that you have read and understand this policy.

Initial_____

Consent for Treatment, Release of Information, Authorization & Assignment of Benefits

- I consent to treatment necessary to my care.
- I authorize the release of all medical records to specialists and/or consulting physicians if applicable to my care and condition.
- I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, its carriers, or any other insurance carrier any information needed for this or any other related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment.
- I further authorize and request that insurance payments be directed to the clinic in which the patient is seen.
- I have read, fully understand and agree to the above consent for treatment, financial responsibility statement, release of medical information & insurance authorizations, and medication refill policy. I also certify that all of the above information is complete and accurate.

Date _____ Patient Name _____Signature_____

Authorization to Treat a Minor
(Ages 0-18th Birthday)

[ ] Not Applicable (patient is an adult)

If there are circumstances when I am unable to bring my child to the office for his/her evaluation and treatment, I give my permission and authorization for the following persons (over the age of 18) to obtain medical care for my child. I also authorize the providers to discuss or disclose information regarding any matters relating to my child's appointment, insurance, test results or medical care to those listed below. This authorization will remain in effect until I provide written notification to the clinic of changes or updates. I authorized the clinic to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care.

Name _____Relationship_____Phone_____

Name _____Relationship_____Phone_____

Name _____Relationship_____Phone_____

Financial and Payment Policies

Notice: Our office does NOT file Auto Insurance claims for visits relating to motor vehicle accidents.

- Payments is due at the time of service. This includes all co-pays, deductibles and co-insurance.
- I authorize direct payment of my insurance benefits to the clinic for services rendered to myself or dependents.
- Insurance will be filed for services rendered. Any changes for services not covered by insurance will be the responsibility of the patient or his/her guardian. I understand that it is my responsibility to know my insurance and billing information.
- Patient or guardian is responsible for notifying our office of any changes to demographics or insurance and billing information.
- Out of network services not paid by the health insurance company will be the responsibility of the patient or his/her guardian.
- The clinic will provide medical information to the insurance company as required for payment of claims for services rendered.

Lab/X-ray/Diagnostic Services:

- I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pays, deductibles and co-insurance due for these services if they are not reimbursed by my insurance.

I have read, fully understand, and agree to the above consent for treatment.

Patient_____Signature_____Date_____