Patient Information Sheet

Please bring Driver's License and Insurance Card

Patient Name: Last: _____ First: _____ Middle: _____

Birth/Maiden Name: _____ Gender: M F SSN# _____

Marital Status: S M D W DOB: ____ / ____ / ____ Race: _____ Ethnic Group: _____ Language: _____

Patient Address: _____ Apt# _____

Zip _____ City _____ State _____ County _____

Phone Home: _____ Phone Cell: _____

Phone Work: _____ **EMAIL:** _____

Preferred Contact Method: [ ] Portal [ ] Cell [ ] Home [ ] Work Preferred Reminder Method: [ ] Cell [ ] Text or Call [ ] Home [ ] Work [ ] Email

Employer _____

Primary Provider/Insurance _____

CoPay Amount $ _____

Owner of Policy _____

DOB of Policy Holder _____

Relationship to Patient _____

Policy Holder Address _____

Secondary Provider/Insurance _____

CoPay Amount $ _____

Owner of Policy _____

DOB of Policy Holder _____

Relationship to Patient _____

Policy Holder Address _____

Responsible Party/Guarantor Information [ ] same as patient Relationship to Guarantor: _____

Name: _____ DOB ____ / ____ / ____ SSN# _____

Address: _____ City: _____ State: _____ Zip _____

Phone: _____ [ ] Home [ ] Work [ ] Cell

Who should we contact in case of an Emergency

Name: _____ Phone: _____

PLEASE READ THE FOLLOWING VERY CAREFULLY

CONSENT FOR TREATMENT: I, the undersigned, consent to the care and treatment by the attending physician, his/her associates or assistants.
ASSIGNMENT OF BENEFITS AND GUARANTEE OF ACCOUNT: I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office are due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event my account is not paid when due and is turned over to a collection agency, I agree to pay all costs of collection fees and/or attorney's fees and all court costs, if any, not to exceed 33.333 %.

Patient/Guarantor Signature: _____ Date: _____

Receipt for HIPAA Privacy Notice and Authorization to Obtain or Release Information (MR119)

By providing this authorization I understand that the authorization is **voluntary** and is being done at the request of the patient. I understand that I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected. I understand that the health information to be obtained and released may be subject to re-disclosure by the recipient of the health information and no longer protected by the federal Privacy Rules. I understand that I may revoke this authorization at any time by notifying in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation. I understand that this authorization is for six (6) years until specified otherwise.

I hereby authorize to use, disclose health information as follows:

Release to: _____ Relation to patient: _____
Name

Address: _____ Phone Number _____

Release to: _____ Relation to patient: _____
Name

Address: _____ Phone Number _____