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Patient Information:

Last Name _____ First _____ MI _____ Date of Birth _____
Address _____ City _____ St _____ Zip _____
Phone Home _____ Work _____ Cell _____
Male _____ Female _____ Race _____ Marital Status _____ SSN _____
Email Address _____ Local Pharmacy _____ City _____

Do you have an Advanced Directives Plan / Living Will? Yes/No Do you have a Medical/Legal Power of Attorney? Yes / No

Name _____ Phone _____

Children only:

Mother's Name _____ Father's Name _____
Address _____
City, St, Zip _____ City, St, Zip _____
Phone _____ Phone _____

Employer _____ City _____ ST _____ Phone _____

Is this an accident? Yes _____ No _____ Work related? Yes _____ No _____ Auto accident? Yes _____ No _____ Date of Injury _____

Notice of Financial Practices:

As part of an effort to provide the best possible medical care to you, we would like to explain our financial policies in advance.

- Your health insurance is a contract between you, your insurance company and, if applicable, your employer. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, coordination of benefits, or precertifications.. Not all services are covered benefits. Please understand that if your insurance does not pay for a particular service, you are responsible for payment in full. It is your responsibility to understand and know your insurance benefits and to inform our office of insurance benefit changes prior to the appointment. Co-pays and deductibles are due at time of service. If insurance is denied, you will be responsible for the total charges. We accept cash, checks, Visa, MasterCard, and Discover Card. All returned checks will be at \$40.00 returned check fee.
- Any forms or letters requested (short-term disability, school, employment, etc) will be completed with a minimum charge of \$50.00 each and could require up to 5-7 business days to complete.
- There may be a charge of \$50.00 for No Show/Late Cancellations of appointments that we are unable to fill. We request that if you must change your appointment, you contact us no later than 24 hours before your scheduled appointment time.
- We do not take walk-ins; however same day appointments can be scheduled if available.
- Prescription refills- we generally do NOT phone in refills nor do we phone in new prescriptions without evaluation.
- Data sharing of medical records, hospital records, and medication history is attached with our EMR.

Privacy:

May we call you, a family member or significant other regarding scheduling, test results or other private issues?

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

May we leave a brief confidential message on voice mail or answering machine? Yes _____ No _____

EMERGENCY CONTACT: _____ Phone: _____ Relation: _____

I have read and understand the Health Information Notice, Financial Notice, and Privacy Notice. I hereby authorize payment directly to the business office of this clinic/provider for surgical &/or medical benefits for services provided. I understand that I am financially responsible for the charges not covered by insurance.

Patient Signature/Responsible Party _____

Relationship to Patient _____ Date _____