



CHART #: _____

PROVIDER: _____

PATIENT INFORMATION

PATIENT NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____

ZIP CODE: _____ CITY: _____ STATE: _____

HOME PHONE #: (____) _____-____ CELL PHONE #: (____) _____-____ EMAIL ADDRESS: _____

DATE OF BIRTH: ____/____/____ SOCIAL SECURITY NUMBER: _____-____-____

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: (circle one) SELF SPOUSE CHILD OTHER SEX: (circle one) FEMALE MALE

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

PATIENT'S EMPLOYER INFORMATION: COMPANY: _____ CITY: _____ PHONE #: _____

RESPONSIBLE (OR INSURED) PARTY INFORMATION

RESP. PARTY NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____

DATE OF BIRTH: ____/____/____ SEX: (circle one) FEMALE MALE

HOME PHONE #: (____) _____-____ CELL PHONE #: (____) _____-____

SOCIAL SECURITY NUMBER: _____-____-____

RESPONSIBLE PARTY'S EMPLOYER INFORMATION: COMPANY: _____

CITY: _____ PHONE #: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

ADDRESS: _____ PHONE: _____

CONTRACT (ID#) NUMBER: _____ SUBSCRIBER'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP NUMBER: _____

COPAYMENT AMOUNT: \$ _____ INSURED'S DATE OF BIRTH: ____/____/____

SECONDARY INSURANCE COMPANY: _____ ADDRESS: _____ PHONE: _____

CONTRACT (ID#) NUMBER: _____ SUBSCRIBER'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP NUMBER: _____

COPAYMENT AMOUNT: \$ _____ INSURED'S DATE OF BIRTH: ____/____/____

**WE APPRECIATE THE OPPORTUNITY OF SERVING YOU.
WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE.**

OFFICE POLICY ON PAYMENT:

It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. In the event any balance due hereunder is not paid as agreed, the undersigned agree to pay all costs charged by the collection company, which costs will not exceed 20% of said unpaid balance, including a reasonable attorneys fee.

INSURANCE POLICY:

Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information. **You are responsible for all deductibles and charges not covered by insurance.** Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

PRIVACY STATEMENT:

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), I have Certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessment and physician certifications

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but you do agree then you are bound to abide by such restrictions.

I have read the above and accept responsibility in full for this account.

SIGNED: _____ **DATE:** _____
Patient, Parent, or Guardian

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME: _____

PHONE NUMBER: _____ RELATIONSHIP: _____

ADDRESS: _____
