Patient Information Form

*Please **print** all information in the spaces provided. Be sure to complete and sign the statement on the back of this form.*

Last Name_____ First Name_____ M.I._____

Home Address_____

Home Phone_____ Work Phone_____

Employer Name and Address_____

Social Security Number_____ Date of Birth_____

Primary Insurance
Company Name and Phone Number_____

Billing Address_____

Name of Insured and Relation to Patient_____

Insured's ID Number_____ Group Number_____

Secondary Insurance
Company Name and Phone Number_____

Billing Address_____

Name of Insured and Relation to Patient_____

Insured's ID Number_____ Group Number_____

Name and Phone Number of person to
contact in the case of an emergency_____

I hereby authorize payment of medical benefits billed to my insurance to _____. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance.

I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered.

I will pay by (check one) □ cash □ check □ credit card.

_____ _____
signature of patient or guardian *date*

Please turn page over

[insert Practice name where appropriate]

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, _____ , hereby authorize _____ to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, _____ can refuse to treat me.

I have been informed that _____ has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying _____ , in writing, but if I revoke my consent, such revocation will not affect any actions that _____took before receiving my revocation.

I understand that _____has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that _____restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that _____does not have to agree to such restrictions, but that once such restrictions are agreed to, _____ must adhere to such restrictions.

_____ _____

Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

_____

Printed name of patient or patient's representative

_____

Relationship to the patient