Doctor: _____

PATIENT INFORMATION

Name: _____ **Patient ID #:** _____ **Sex:** [ ]M [ ]F

Address: _____ **Date of Birth:** _____ **Age:**

_____ **Social Security #:** _____

City,State, Zip: _____ **Preferred Language:** _____

Phone: _____ [ ]Home [ ]Work [ ]Other **Marital Status:** [ ]Married [ ]Single [ ]Divorced

Phone: _____ [ ]Home [ ]Work [ ]Other **Email Address:** _____

Phone: _____ [ ]Home [ ]Work [ ]Other **Referring Physician:** _____

Ethnicity: [ ]Hispanic or Latino [ ]Non Hispanic or Latino [ ]Other **Primary Physician:** _____

Race: [ ]American Indian or Alaska Native [ ]Asian [ ]Black or African American [ ]Native Hawaiian or Other Pacific Islander [ ]White or Caucasian [ ]Other or Undetermined

PATIENT EMPLOYMENT INFORMATION

[ ]Employed [ ]Retired [ ]Unemployed [ ]Other

Employer's Name: _____

Employer's Phone: _____

Occupation: _____

EMERGENCY CONTACTS

Name	Relationship	Phone

RESPONSIBLE PARTY *(If patient is under 18 years of age)*

Name: _____ **Employer:** _____

Address: _____ **Home Phone:** _____

_____ **Work Phone:** _____

City,State, Zip: _____ **SSN:** _____

Date of Birth: _____

PRIMARY INSURANCE

Insurance Company Name: _____

ID #: _____

Group/Policy #: _____

Subscriber's Name: _____

Subscriber's Phone #: _____

Relationship to Patient: _____

Subscriber's Employer: _____

Subscriber's SS #: _____

Subscriber's Date of Birth: _____

SECONDARY INSURANCE

Insurance Company Name: _____

ID #: _____

Group/Policy #: _____

Subscriber's Name: _____

Subscriber's Phone #: _____

Relationship to Patient: _____

Subscriber's Employer: _____

Subscriber's SS #: _____

Subscriber's Date of Birth: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my illness to my insurance carrier. ***I understand that I am responsible for any amount not paid for by my insurance.***

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

I authorize the clinic to obtain medication history electronically from my pharmacy benefit administrator.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO MAKE PAYMENT DIRECTLY TO:
ACCREDITED FAMILY HEALTHCARE

I understand that I am financially responsible for any co-payments, deductibles, coinsurance, and all charges, which are not covered by my insurance at the time of service. I understand that verification of coverage is not a guarantee of benefits. Insurance benefit payment is determined by your insurance company when the claim is received. I understand I will be responsible for all portions not covered by insurance. Please be aware there is a $25.00 fee for a missed office visit or canceled office visit for which you do not give 24 hours notice. The doctor has allowed time for your visit, so if you need to cancel, please call 24 hours ahead to let us know. Please be aware there is a $35.00 returned check fee for any returned checks.

I understand that Accredited Family Healthcare does not accept liens. We are happy to file your insurance for you, however, please understand that you are responsible for all charges if it is determined that the insurance information you have provided is not correct and that it is your responsibility to notify our office if there are any changes in your insurance whatsoever. Due to the large amount of insurance plans and policies, it is impossible for the physicians and staff to know what services are/are not covered. It is the patient's responsibility to be aware of the services covered by the patient's plan and to be aware of what laboratory your insurance will permit your lab work to be processed at. Our lab of choice is **Sonora Quest/LAB Corp.** We use **Lab Corp** for any United Healthcare patients. If your insurance company requires that it be processed elsewhere, it is your responsibility to inform both the nurse and doctor of this fact.

I understand that delinquent accounts will be turned over to an attorney or collection agency without notice. I understand that an account will be considered delinquent if unpaid after 60 days of billing date. I understand that in the event my account is turned over for collection, I am responsible for a $35 collection fee and 100% of court costs, attorney's fees, etc. at the time the account is considered delinquent.

I hereby authorize Accredited Family Healthcare to release any medical or incidental information to my referring physician or any other physicians who have been or may become involved in my care; and the release and obtaining of any medical records including reports of a psychological or psychiatric nature, drug abuse, alcoholism, AIDS results, and pharmacy records. I also authorize the release of information that may be necessary in the processing of any insurance claims.

If you have not been seen in our office in the past 3 years your chart will automatically be made inactive.

Patient statements are sent via patient portal. Initial _____
EMAIL _____

Due to the HIPPA laws now in effect we must have detailed information as to whom we may release medical information. Please read and check the appropriate areas as you see fit. This release is valid until you notify us in writing otherwise.

To whom may we release your medical, financial, and billing information?

___Spouse_____ ___Other _____

___Sibling_____ ___Son or Daughter_____

___Parent _____

May we leave a message on your answering machine confirming an appointment or informing you that there are test results that you need to call us regarding? ___Yes ___No

Your signature indicates complete understanding and agreement to all information contained on this page. If you have questions, please feel free to discuss with the receptionist prior to signing below.

Signature of
Patient/Guardian_____Date_____

Patient Name_____DOB_____

PATIENT NAME: _____ DOB: _____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

_____ _____

Patient or legally authorized individual signature **Date**

_____ _____

Printed Name **Relationship (parent, legal guardian, Personal representative, etc.)**

PHONE VOICEMAIL AUTHORIZATION FOR RELEASE OF BILLING INFORMATION

☐ I **DO** give authorization for *Accredited Family Healthcare* to release any of my billing information by phone voicemail to my [select **one** phone type and write the phone number].

Home/Work/Cell: _____

☐ I do **NOT** authorize *Accredited Family Healthcare* to release any of my billing information by phone voicemail.

I understand that the authorized voicemail(s) above may contain detailed and sensitive health, financial and insurance information. I also understand that the authorized voicemail(s) box provided above is set up, in working order and has the space available to receive voicemail messages.

This consent will remain in effect until it is revoked in writing by the patient.

Patient/Guarantor Signature: _____ Date: _____