Medical Insurance Information

Patient_____ DOB _____/_____/_____ Age_____ Sex_____
Last First

Social Security # _____-_____-_____ Phone (_____) _____ Marital Status_____

Home Address_____
Street City State Zip

Employer _____
Street City State Zip

Parent, Spouse, or Responsible Party_____
Name Relationship

Contact Information_____
Address Phone

Emergency Contact_____
Name Address Phone

Referred by_____
Name Address Phone

Are you presently a member of an HMO health plan? YES NO (please circle)

Are you currently enrolled in Hospice? YES NO (please circle)

Primary Insurance:

Insurance Company_____ Group Policy # _____

Policy Holder _____ Member/ID # _____

Date of Birth _____/_____/_____ Sex_____ Patient Relationship to Policy Holder_____

Primary Care Physician_____ Referring Medical Group_____

Secondary Insurance:

Insurance Company_____ Group Policy # _____

Policy Holder _____ Member/ID # _____

Date of Birth _____/_____/_____ Sex_____ Patient Relationship to Policy Holder_____

Primary Care Physician_____ Referring Medical Group_____

Consent for use and disclosure of protected health information

By signing below, you consent to the use and disclosure of your protected health information by our office for treatment, payment, and health care operations. For a more detailed explanation, please review our Notice of Information Practices posted at the front desk.

Patient or Guardian's Signature_____ Date_____

Name_____ Home Tel (_____) _____
Last First Dr. Mr. Ms. (Circle One)

Address_____ Today's Date _____/_____/_____

City and State_____ Zip _____

Employer_____ Occupation_____

Employer Address_____ Employer Tel (_____) _____

Who referred you?_____

Reason for visit? _____

Are you currently enrolled in Hospice? YES NO (please circle)

Do you have allergies to any medications? YES NO (please circle)
If yes, please explain_____

Have you ever had any surgery? YES NO (please circle)
If yes, please explain_____

Do you take any medications? YES NO (please circle)
If yes, list_____

Have you had any of the following problems? If yes, please explain:	(please circle)	
Chronic fever, weight loss/gain, fatigue?	YES	NO
Ear/nose/throat problems? (hearing loss, sinus problems, sore throat)	YES	NO
Heart problems: (chest pain, irregular heart beat hypertension)	YES	NO
Respiratory problems? (shortness of breath, asthma, bronchitis)	YES	NO
Gastrointestinal problems? (heartburn, abdominal pain, diarrhea)	YES	NO
Urinary Problems? (pain, bladder problems, blood in urine)	YES	NO
Musculoskeletal problems? (aches, arthritis, swollen joints)	YES	NO
Psychiatric problems? (depression anxiety)	YES	NO
Do any medical or eye diseases run in the family?	YES	NO
Do you smoke or consume alcohol? If yes, how much?	YES	NO

Women, are you pregnant: YES NO
If yes, how many months? _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone: _____

☐ OK to leave message with detailed information

OR

☐ Leave Message with call-back number

☐ Work Telephone: _____

☐ OK to leave message with detailed information

OR

☐ Leave Message with call-back number

☐ Written Communication

☐ OK to mail to my home address

☐ OK to mail to my work/office address

☐ OK to fax to this number: _____

☐ Other: _____

_____

_____ _____

Patient Signature Date

_____ _____

Print Name Birth date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized

(2) Type Key: T= Treatment Records; P=Payment Information; O= Healthcare Operations; A= Authorization on File; D= Discretionary

(3) Enter how disclosure was made: F= Fax; P= Phone; E= Email; M= Mail; O= Other

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INSURANCE NON-COVERED SERVICE AGREEMENT

NOTICE TO BENEFICIARY

Insurance companies will only pay for services that it determines to be "reasonable and necessary". If your insurance company determines that a particular service not "reasonable and necessary" under their set policy, they will deny payment for that service. If your insurance denies your service, you will be responsible for payment.

BENEFICIARY AGREEMENT

I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR ANY UNPAID BALANCE THAT MY INSURANCE CARRIER DENIES.

Print Name _____ Insurance Co. _____

Signature _____ Date _____