WELCOME TO OUR PRACTICE

NEW PATIENT PACKET

Dear Patient,

Welcome to our practice. .We are very glad you have chosen us for your care. Please find enclosed your information packet for your upcoming visit to our office. For your convenience please have these filled out and bring them with you to your appointment along with your insurance card. **Please plan to arrive at our office 30 minutes prior to your appointment time**. This will give us an adequate time to get your information into our system and established as a patient with our office .

Thank you for choosing our office for your healthcare needs and we look forward to seeing you.

PATIENT INFORMATION

PATIENT INFORMATION

First Name_____ M.I_____ Last Name_____ Sex ☐ M ☐ F

Birth Date _____ Age ____ SSN _____ Marital Status: ☐ Single ☐ Married ☐ Divorced

Street Address_____ Apt._____ City _____State_____ Zip _____

Home Phone _____ Cell _____ Other _____

EMPLOYMENT INFORMATION

Employer _____ Address_____

City _____State_____ Zip _____ Phone _____ Ext ____

EMERGENCY CONTACTS

First Name_____ M.I_____ Last Name_____ Sex ☐ M ☐ F

Street Address_____ Apt._____ City _____State_____ Zip _____

Home Phone _____ Cell _____ Relationship to Patient _____

First Name_____ M.I_____ Last Name_____ Sex ☐ M ☐ F

Street Address_____ Apt._____ City _____State_____ Zip _____

Home Phone _____ Cell _____ Relationship to Patient _____

INSURANCE INFORMATION

Insurance Name_____ Address_____

City _____State_____ Zip _____ Phone _____

ID/Certificate Number _____ Group ID/Number _____ Employer/Company _____

Policy Holder (Subscriber) Name _____ Subscriber Birth Date_____ Subscriber Sex ☐ M ☐ F

Insurance Name_____ Address_____

City _____State_____ Zip _____ Phone _____

ID/Certificate Number _____ Group ID/Number _____ Employer/Company _____

Policy Holder (Subscriber) Name _____ Subscriber Birth Date_____ Subscriber Sex ☐ M ☐ F

Payment for office service is due on the day of the visit. Payment may be made by CHECK, CASH, OR VISA/MASTERCARD. An itemized copy of the services provided is available to you for insurance purposes. Insurance/financial arrangements should be made with our office prior to insertion procedure.

PHYSICIAN-PATIENT AGREEMENT: I, the undersigned, authorize_____ to release any information acquired in the course of examination or treatment to my insurance company (s), another physician or as required by court ordered subpoena. I, recognize that the medical insurance I possess may not completely cover the fee(s) for professional services rendered to me, hereby agree that I am responsible for said fee(s). I authorize payment directly to and assign to _____ the surgical/ medical benefits, if any, otherwise payable to me for their services. A photostatic copy hereof shall be as valid as the original. I am aware that I may inquire of my physician the fee(s) for any professional services requited and/or rendered.

PATIENT SIGNATURE:_____ DATE: _____

MEDICAL INFORMATION RELEASE

Please give us the following information:

With whom may we discuss your medical condition?

Name_____

Phone _____

Relationship _____

Name_____

Phone _____

Relationship _____

May we leave a message for you on your voicemail? ☐ Yes ☐ No

May we contact you at your place of employment? ☐ Yes ☐ No

May we leave a message for you at your place of employment? ☐ Yes ☐ No

May we download your medication history from your pharmacy? ☐ Yes ☐ No

What is your preferred pharmacy:_____

I understand that once the physicians and/or staff of _____release my medical information in the above situations that _____ will have no control over to whom these individuals may reveal my information. I understand that I may revoke any of the above authorizations by giving written notice to_____.

PATIENT SIGNATURE:_____ DATE: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information (medical record) may be used by staff members and physicians or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members or physicians.

Payment. Your health information (medical record) may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive info11nation on dates of service, the services provided, and the medical condition being treated.

Healthcare operations. Your health information (medical record) may be used as necessary to support the day-to-day activities and management of _____. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality healthcare.

Law enforcement. Your health information (medical record) may be disclosed to law enforcement agencies to support government audits and inspections to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information (medical record) may be disclosed to public health agencies as required by law, For example, we are required to report certain communicable diseases to the states public health department.

Other uses and disclosures. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Fundraising. It is not the practice of _____ to engage in fund raising projects internally or in cooperation with outside companies or businesses.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIYACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of _____. This notice provides information about how we may use and disclose your protected health information. We encourage you to read it.

I have received a copy of the Notice of Privacy Practices for_____.

PRINTED NAME OF PATIENT:_____ DATE: _____

PATIENT SIGNATURE:_____ DATE: _____

SIGNATURE of Patient Representative: _____ DATE: _____
If patient is a minor or an adult who is unable to sign this form.

RELATIONSHIP of Patient Representative to Patient: _____

********** FOR OFFICE USE ONLY **********

This section to be completed if no signature is obtained above. If it is not possible to obtain the individual's acknowledgment: and the reasons why the acknowledgment was not obtained:

SIGNATURE of Provider Representative: _____ DATE: _____

Efforts made to distribute notice: