**Acute Care+ Family Clinic of Mooreville**

Last Name: \_ \_

\_ \_ \_

\_ \_ \_ \_ \_ \_

\_ First Name. Middle Name \_

Mailing Address: City: State: Zip: \_ \_ \_ \_ \_

Home Phone: Cell Phone: Email:

Social Security No. Date of Birth: \_ \_ \_ \_

\_ \_ Sex: \_ \_

\_ Race: \_

Marital Status: Married

Single\_

\_ Widow

Divorced

. Employer: Contact Name/ Supervisor: Work Phone: Occupation: \_ Spouse's Name: Spouse's Phone: \_ **Emergency Contact Name: Phone:** \_ **Relationship to Patient:**

Other Nurse Practitioner or Physician: \_ \_

\_ \_ \_ \_ \_ \_

\_ \_ \_

\_ \_ \_ Phone: \_

How did you hear about us? \_ \_

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# Insured's Name (if not self):

**Date of Birth:** \_

**Relationship to Patient:** \_ \_ \_ \_

\_ \_ \_

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**Insured's Employer:** \_ \_

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AUTHORIZATION AGREEMENT:

I hereby irrevocably authorize Acute Care + Family Clinic of Mooreville, LLC. for the purpose of billing, to furnish insurance carriers concerning any illness/accident for which I am treated in this clinic, and I hereby irrevocably assign to Acute Care + Family Clinic of Mooreville, LLC. all payments for medical services rendered. I understand that I am financially responsible for charges whet her or not covered by insurance, and if I fail to pay any amount due, I will be responsible for all collection fees, court costs, attorney fees, and any other charges incurred in the collection of the

balance due.

I authorize Acute Care + Family Clinic of Mooreville, LLC. to initiate a complaint to the insurance commissioner for any reason on my behalf.

I consent to care encompassing diagno stic procedures and medical treatment by any physician, nurse practitioner, or other medical professionals in this office, as my health care provider deems necessary. I understand that I will be billed for services performed. I acknowledge that no guarantees have been made as to the results of treatment or examinations. I further agree not to file any claims against this clinic or any health care provider employed by Acute care

+ Family Clinic of Mooreville, LLC. I accept their decisions in full faith that they are providing proper treatment to the

best of his/her knowledge and medical training.

I give permission for my work/school excuse to be faxed to the appropriate facility when necessary.

I acknowledge that I have received, read, and understand the "Notice of Privacy Practice" given to me by this clinic. I understand it is my responsibility to notify the office personnel of this clinic if I wish to amend this "Notice of Privacy Practice."

# The following people have permission to discuss/review my healthcare information:

Signature of Patient or Responsible Party \_ Date: - - - - - -