**Family Clinic of New Albany**

**Please Print**

**Full Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_ Race: \_\_\_\_\_

**Mailing Address (city, state, zip):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt Phone: \_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_\_\_\_\_\_ Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Phone: \_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact (REQUIRED)**:\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_

How were you referred to this practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information (Policy Holder information required to bill insurance)**

Primary Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date of Policy Holder:\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance:\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date of Policy Holder:\_\_\_­­\_\_\_\_\_\_

*Authorization Agreement:*

*I hereby irrevocably authorize Family Clinic of New Albany, Inc. 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 Family Clinic of New Albany, Inc. all payments for medical services rendered. I understand that I am financially responsible for charges whether 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 Family Clinic of New Albany, Inc. to initiate a complaint to the insurance commissioner for any reason on my behalf.*

*I consent to care encompassing diagnostic 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 Family Clinic of New Albany, Inc. 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 the clinic if I wish to amend this “Notice of Privacy Practice.”*

**Signature of Patient of Responsible Party**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party Information Form for Minors**

**Family Clinic of New Albany**

Name of Child(ren):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Custodian of Child(ren):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Guardian/Mother**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_ Social:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Guardian/Father**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_ Social:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give permission to the following people to bring my children to the clinic and seek whatever medical care that is determined to be needed by the practitioner. I understand I will not be contacted by the clinic prior to my children being treated. I also understand this permission will remain in effect until I revoke it in writing.*

|  |  |  |
| --- | --- | --- |
| **Name** | **Relationship to Child** | **Contact Information** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Signature of Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FCNA Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Privacy Agreement**

**Family Clinic of New Albany**

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

|  |  |  |
| --- | --- | --- |
| **Name** | **Relationship** | **Contact Information** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

***I understand that only those individuals listed above or otherwise covered by HIPAA law will be able to contact my doctor’s office for information regarding my healthcare. I understand that these names must be changed in writing if I no longer wish for someone to be on my patient privacy. I will not hold Family Clinic of New Albany responsible for any problems this may cause as they are following my request.***

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

**OR**

***I understand that by not listing anyone above that no one will be able to call the clinic in my place including but not limited to if I were hospitalized or otherwise unable to call myself. I am willing to take this risk and will not hold accountable Family Clinic of New Albany for any problems this may cause as they are following my request.***

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