Name and address of HD

PATIENT INFORMATION SHEET

Please Print

Medical Records#: _____ **HD to include how the patient prefers to be contacted – include TEXT & EMAIL**

PERSONAL INFORMATION:

Date:_____

Patients Name:_____ Date of Birth:_____ SSN:_____
First MI Last

Address:_____
Street City State Zip Code

Marital Status: S M Sep W D Home Phone:_____ Cell Phone:_____ Email:_____

Employer:_____ Occupation:_____ Work Phone:_____

Employer's Address:_____ Which phone preferred as contact: H ❑ C ❑ W ❑

Spouse's Name:_____ Work Phone:_____

Emergency Contact:_____ Relation to Patient:_____ Phone:_____

Referred by:_____

INSURANCE INFORMATION:

Primary Insurance Co.:_____ Effective Date:_____

Address:_____ Phone:_____

Policyholder's Name:_____ Relation to Patient:_____

Member ID #:_____ Group #:_____ Policyholder's Date of Birth:_____

Secondary Insurance Co.:_____ Effective Date:_____

Address:_____ Phone:_____

Policyholder's Name:_____ Relation to Patient:_____

Member ID #:_____ Group #:_____ Policyholder's Date of Birth:_____

PERSON RESPONSIBLE FOR PAYMENT OR INSURANCE POLICYHOLDER (IF OTHER THAN PATIENT):

Legal Name:_____ Effective Date:_____
First Middle Last

Address:_____ Phone:_____
Street City State Zip

Date of Birth:_____ Sex: M F Marital Status: S M Sep W D

Employer's Name:_____ Occupation:_____

Employer's Address:_____ Work Phone:_____

PATIENT CONSENT, AGREEMENT OF FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:

I, the undersigned, voluntarily consent to treatment by the physician(s) and staff of (the Practice). I also voluntarily consent to the use and disclosure of my protected health information for treatment, payment and operations and such other purposes that are permitted under the federal Health Insurance Portability and Accountability Act without a written authorization. I accept that I am financially responsible for all services rendered on my behalf by the Practice. For those insurance plans for which the Practice accepts assignment, I accept personal responsibility for all co-payments, deductibles and non-covered services, as dictated by my insurance coverage, plus any collection costs for amounts personally owed by me, including attorney fees if necessary. I authorize payment directly to the Practice for services for which the Practice accepts assignment. A copy of this agreement may be used in place of the original. I certify that the information stated on this form is correct. **LHD will need to include information about Central Collections Unit (CCU) and their 17% fee.**

_____ _____
Signature of patient or Parent/Legal Guardian Date

PRIVACY NOTICE ACKNOWLEDGEMENT

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

_____ _____
Name of Individual (Printed) Date of Birth

_____ _____
Signature of Individual or Personal Representative Relationship if other than patient

(SHR 4/10)