**PATIENT INFORMATION:** **DATE: _____**

NAME (LAST, FIRST, MI) _____

ADDRESS _____

CITY, STATE, ZIP _____

PHONE _____ ALTERNATE PHONE _____

BIRTHDATE _____ SEX _____ MARITAL STATUS _____ SOCIAL SECURITY _____

RACE/ETHNICITY (please circle): American Indian or Alaskan Native, Asian, Black or African American, White or Caucasian, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, Native American, Other: _____

PREFERRED LANGUAGE (please circle): English, Spanish, Navajo, German, French, Other: _____

**MANDATORY PERSON TO CONTACT IN CASE OF EMERGENCY:**

NAME _____ RELATIONSHIP _____ PHONE _____

**REFERRING DR _____** PHONE _____

PRIMARY CARE DR: _____ PHONE _____

## INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____

SECONDARY INSURANCE COMPANY _____

(COMPLETE INFORMATION BELOW IF OTHER THAN YOURSELF)

PRIMARY CARDHOLDER'S NAME/RELATIONSHIP _____

DOB _____ SOCIAL SECURITY # _____

SECONDARY CARDHOLDER'S NAME/RELATIONSHIP _____

DOB _____ SOCIAL SECURITY # _____

## FINANCIAL AGREEMENT

The financial policy of the practice has been fully explained to me and I acknowledge full responsibility for all charges incurred including any additional charges incurred in the collection of this account, if my insurance later determines my services to be noncovered or not a benefit.

**PATIENT SIGNATURE: X _____ DATE _____**

**EMPLOYEE WITNESS _____ DATE _____**

## PRIVACY POLICY (HIPAA)

I understand that HIPAA has implemented procedures that require specific authorization for release of my information. I agree to the following statements and understand that I can revoke these at any time by informing the Privacy Officer in writing.

**Home telephone #:** We may leave a message with a callback number or appt reminder on voicemail.

**Written communication:** We may mail postcards to your home address or send you an e-mail.

I have received the NOTICE OF PRIVACY PRACTICES and I have been provided an opportunity to review it.

I understand that the last four digits of my social security number will be used as a password to identify persons seeking information regarding my health care, e.g. for test results, prescription refills, billing info. If I would like a different code assigned, I will list it here: _____. I will give this code to my family members or friends who may need to call the practice on my behalf. Without this code the physicians or staff members will not be able to speak with anyone except myself.

**PATIENT SIGNATURE: X _____ DATE _____**

## LIFETIME INSURANCE AUTHORIZATION

I authorize and request that payments under my medical insurance programs be made directly to pay the provider for any services furnished to me. I also authorize the provider to release any information needed for payment of claims. I further permit copies of this authorization to be used in place of the original.

**PATIENT SIGNATURE: X _____ DATE _____**