PATIENT NAME ____ **DOB** ________________

Social Security# ____ **Sex** (please circle one) M F

Race: ______________ **Pharmacy:** ____

E-Mail: ____

Who referred you to us: ____

Marital Status (please circle one) S M W D Sep

Patient Mailing Address____
City_______________________________________ State _________________ Zip_________
Phone: **(H)**_______________________ **(W)**_________________________ **(Cell)**______________

If Patient is Married, Full Name of Spouse____

Name of Primary Insurance Company____
Effective Date________________ Employer ______________________________________
Policy Number _________________________________Group # ______________________
Insurance Address____
Name of Insured Employee______________________________ Relationship to Patient__________
Insured Employee's SS # ______________________________Insured's DOB_______________
Mailing Address of Insured (if different from Patient)_______________________________
City_______________________________________ State _________________ Zip_________
Phone: **(H)**_______________________ **(W)**_________________________ **(Cell)**______________

Name of Secondary Insurance, If Any____
Effective Date________________ Employer ______________________________________
Policy Number _________________________________Group # ______________________
Insurance Address____
Name of Insured Employee______________________________ Relationship to Patient__________
Insured Employee's SS # ______________________________Insured's DOB_______________
Mailing Address of Insured (if different from Patient)_______________________________
City_______________________________________ State _________________ Zip_________
Phone: **(H)**_______________________ **(W)**_________________________ **(Cell)**______________

I agree that the information supplied on this form is accurate and up to date to the best of my knowledge.

) ****I hereby acknowledge that I have received or been provided the opportunity to receive a copy of the HIPAA privacy policies** and understand that any questions or complaints may be addressed to the Privacy Officer without penalty (Office Manager) .

❈**Patient Signature**____ Date________________

Consent for Treatment

I hereby authorize Family Health Center of Coppell to use and/or disclose my health information which specifically identifies me or which can reasonable be used to identify me to carry out my treatment, payment and healthcare operations. I understand that while my consent is voluntary, if I refuse to sign this consent, the healthcare providers of Family Health Center of Coppell may refuse to treat me. I authorize the physicians to administer such treatment as they deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician or nurse practitioner and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered valid as original,
Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and or percentage which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain referral forms from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency which will leave you liable for any additional charges incurred. I have fully read and understand the above payment policy. I agree to forward to Family Health Center of Coppell, all insurance or third party payments that I receive for services rendered to me immediately upon receipt.

MEDICARE LIFETIME AUTHORIZATION

I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.
I request this authorization also apply to all other insurance.

***Patient Signature**________________________________Date_______________________

RELEASE OF MEDICAL INFORMATION

Please let us know the names of who we may release health information to or may be allowed to enter the exam room during discussion regarding health information. I understand that I may request individuals to leave the exam room at any time

Name of Person who is Authorized to receive information	Release info (please circle)	Allowed in exam room (please circle)
______________________________	Y N	Y N
______________________________	Y N	Y N
______________________________	Y N	Y N
______________________________	Y N	Y N
______________________________	Y N	Y N

***If the requestor/receiver of information is not a healthcare provider, the released information may no longer be protected from re-disclosure**

What information may we release:

_____All PHI (Personal Health Information)
_____Office notes
_____Lab/ Diagnostic test results
_____Appointment information
_____Billing information
_____Psychotherapy/mental health
_____Prescription
_____Other

This information may be released by:

_____Phone: Phone #_____________________
_____Fax: Fax #_________________________
_____Mail: Address______________________
____
_____Other (please be specific)_____________

This authorization for release of information expires: __________________________________

***Patient Signature**____

Date____________________________ **Patient Date of Birth**_____________________