

Doctor's Clinic

PATIENT INFORMATION: (Please Print)

Name: _____ SS#: ____/____/____
Address: _____
City: _____ State: _____ ZIP: _____
Home Phone: _____ Cell Phone: _____
Date of Birth: ____/____/____ Age: ____ Sex: ____ Martial Status: _____
Employment Status: Employed Retired Unemployed Other _____
Occupation: _____
Employer: _____ Work Phone: _____
Employer Address: _____

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name: _____ SS#: ____/____/____
Address: _____
City: _____ State: _____ ZIP: _____
Home Phone: _____ Cell Phone: _____

INSURANCE INFORMATION / POLICY HOLDER

Do you have insurance? Yes No

Primary Insurance: _____

Subscriber ID #: _____ Group #: _____

Name of Cardholder: _____

Date of Birth: ____/____/____ SS#: ____/____/____

Secondary Insurance: _____

Subscriber ID #: _____ Group #: _____

Name of Cardholder: _____

Date of Birth: ____/____/____ SS#: ____/____/____

OTHER INFORMATION:

Pharmacy of choice: _____ Phone: _____

Emergency contact: _____

Relationship to Patient: _____ Phone: _____

ASSIGNMENT OF BENEFITS:

I assign all payments to which I am entitled or may become entitled for medical and/or surgical expenses for products and/or services provided by Doctor's Clinic / Ferrell Hospital Community Foundation. This includes Medicare, private insurance and other health plans. A photocopy of this assignment is to be considered as valid as the original.

Initial

AUTHORIZATION TO RELEASE INFORMATION:

I authorize Doctor's Clinic to release to the Social Security Administration and the Center for Medicare and Medicaid Services (CMA, formerly HCFA) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place to the original signed assignment. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (section 1128B of the Social security Act and 31U.S.C.3801-3812 provides penalties for withholding this information).

We will file claims and all necessary documentation for claim processing as a courtesy to you and your insurance company(s).

Initial

PATIENT FINANCIAL RESPONSIBILITY:

I understand that I am responsible for all co-payments, deductibles and other charges not covered by insurance companies or other benefits I am entitled to receive.

I understand that if my insurance company has not paid my claim after 90 days, I am responsible for the full amount and payment is due immediately.

Initial

HIPAA NOTICE OF PRIVACY PRACTICES:

I authorize and agree that my health information may be used for treatment, payment and healthcare operations. I have received my HIPAA Notice of Privacy Practices.

Initial

CONSENT TO TREATMENT:

I authorize Doctor's Clinic to render medical services, including diagnosis and treatment, laboratory testing, x-rays and other medical services as deemed necessary.

Initial

If the patient is under the age of 18 years or unable to read or understand the above, this form must be signed by a competent adult responsible for the care of the patient. The responsible adult assumes all obligations as outlined above.

Patient or Responsible Party Signature

Date Signed

Relationship to Patient

Please give receptionist a current copy of your insurance card(s).