Referral information, Patient Financial Policy and Signature on File

Patient Name:____ Today's Date ___/___/___

Other family members that are patients ____

Referred by: ____

Primary Care Physician ____________________________ Phone (   )______________

EMERGENCY CONTACT INFORMATION:

In case of Emergency, who should be notified?_____________________ Phone (   )_____________

Relationship to patient: ______________________________________

Do you give our office permission to discuss your medical information with family members?

❑ YES ❑ NO If yes, please provide their names and phone numbers below.

Name: ___________________________________ Relationship: _________________________

Phone # (day): (_____)______________ Phone # (evening): (_____)________________

May we leave personal medical information on your answering machine or cell phone? ❑ YES ❑ NO

May we e-mail personal medical information to you? ❑ YES ❑ NO

E-mail address: _______________________________________

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature _______________________________ Date ___/___/___

PAYMENT POLICY:

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. Payment is required for all services at the time they are rendered. We accept payment in the form of cash, check or credit card. You may be asked to pay any unmet deductible, non-covered services and copayments. In the event your account must be turned over to collections, a $10 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

__________________________________ ___/___/___

Patient or Responsible Party Signature Date