

Patient Information Sheet

***If you have symptoms of **chest pain, seizures, head injury, severe bleeding, shortness of breath, chemical in eye, or anything of concern**, please notify the receptionist immediately so appropriate action can be taken!

***If this is related to an **Auto (Car) accident** or **Industrial (Work) Injury**, please notify receptionist if you have not done so already.

Patient Information	Patient's Last Name _____ First _____ Middle _____ Address _____ City _____ State _____ Zip _____ Home Phone () _____ Cell phone # () _____ Birth date ____/____/____ Age _____ Male Female Single Married Other Social Security # _____ - _____ - _____ Employer _____ Spouse's Name _____ Spouse's date of birth ____/____/____
Contact	Emergency Contact _____ Phone () _____ Relationship to Patient _____ Alternate Phone () _____
Guarantor	<p style="text-align: center;">If patient is 17 or under, please complete this section:</p> Name of Parent/Guardian who brought the patient to be seen _____ Date of birth ____/____/____ Social Security Number ____/____/____ Relationship to patient _____
Primary Insurance	Insurance Name _____ Telephone () _____ Group # _____ Policy # _____ Submit Claim Address _____ Primary Card Holder's Name _____ Date of birth ____/____/____ Social Security # ____/____/____ Employer _____ Work phone _____
Secondary Insurance	Insurance Name _____ Telephone: () _____ Group # _____ Policy # _____ Submit Claim Address _____ Primary Card Holder's Name _____ Date of birth ____/____/____ Social Security # ____/____/____ Employer _____ Work phone _____
Consent to Treat	I hereby consent to and authorize the administration and performance of all treatments and operations and the administration of any anesthetics, which in the judgment of the attending provider may be considered necessary or advisable. If I should leave the clinic without written consent of my attending provider, I hereby relieve said provider and the clinic of all responsibility for my action. I authorize the clinic to furnish my insurance carriers copies of all my medical records for the purpose of payment and/or continued care and treatment. This consent is good for the year 20____. Patient's Signature _____ Date _____ Guarantor's Signature _____ Date _____ <p style="text-align: center;">(if patient is 17 year old or younger)</p>

Contract to Pay for Medical Services Authorization to Release Medical Information	<p>In consideration of professional services rendered to the patient, I/we agree to pay the customary charge for these services in full at the time of service, unless other arrangements have been made with FirstMed. I/We authorize FirstMed to receive assignment of insurance payments for services rendered. If the customary charges are more than the benefits allowed under any insurance plan that I/we hold, I/we agree to pay the difference.</p> <p>I/We, the undersigned, recognize that FirstMed cannot accept responsibility for collections, any insurance claims, or negotiating any settlement on a disputed claim. I/We also agree in the event of default in the payment of any amount due, and if this account is placed in the hands of an agency or attorney for collection or legal action, to pay an additional charge to the cost of collection including agency and attorney fees and court costs incurred and permitted by the laws governing these transactions.</p> <p>I/We hereby authorize FirstMed to release any medical or incidental information necessary for either medical care or the process application for financial reimbursement.</p> <p style="text-align: center;"><i>I/We, the undersigned, understand a \$10 fee will be billed for co-pay amounts not paid at the time of service. I/we also understand a \$25 fee will be billed for all checks returned for insufficient funds.</i></p> <p style="text-align: center;">I/We have read the Contract to Pay for Medical Services and give the Authorization to Release Medical Information.</p> <p>Patient Signature: _____ Date: ____/____/____</p> <p>Guarantor's Signature: _____ Date: ____/____/____ (if patient is 17 years old or younger)</p>
Self Pay Policy	<p style="text-align: center;">Office Visits</p> <p style="text-align: center;">At the time of service, all new patients will be required to pay \$125 for an office visit. At the time of service, all established patients will be required to pay \$60 for an office visit. <i>This must be collected before you see the medical provider.</i></p> <p style="text-align: center;">Additional Services</p> <p>All procedures (care for fractures, lacerations, foreign body removal), all supplies (orthopedic splints, crutches, dressings, medications), all x-rays and all lab tests will be charged in addition to the office visit. FirstMed will discount additional services by 30% if paid for at the time of service. All additional service charges not paid at the time of service (before you leave) will not receive a discount and will be billed to you at full service fee.</p> <p style="text-align: center;">I have read and understand the Self Pay Policy. I will be responsible for my bill as explained to me.</p> <p>Patient Signature: _____ Date: ____/____/____</p> <p>Guarantor's Signature: _____ Date: ____/____/____ (if patient is 17 years old or younger)</p>
Medicare Beneficiary Signature on File	<p>I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I give my permission for a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the the party who accepts assignments. Regulations pertaining to Medicare Assignment of Benefits apply.</p> <p>Patient Signature: _____ Date: ____/____/____ (for Medicare Insured only)</p>
HIPAA Notice Signature on file	<p>Effective date: _____</p> <p>I acknowledge receipt of a copy of the FirstMed HIPAA Notice.</p> <p>Patient Signature: _____ Date: ____/____/____</p> <p>Guarantor's Signature: _____ (if patient is 17 years old or younger)</p> <p>Relationship to patient: _____</p> <p>Signature of Witness or Clinic Representative: _____ Date: ____/____/____</p>