PATIENT INFORMATION

Name (Last, First, Middle) | Alias/Maiden

Birthdate / / | Soc Sec #: – – | ☐ Male ☐ Female | ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed

Address | Skilled Nursing Facility? ☐ | Apt | City | State | Zip

Primary Phone | Work Phone | Other Phone

☐ African American ☐ Caucasian ☐ Asian ☐ Hispanic ☐ Native American/Inuit ☐ Pacific Islander ☐ Decline ☐ Other:

Religion (Specific to medical needs or requirements): None ☐

☐ Needs Interpreter | Language:

Primary Care Physician:

Emergency Contact | Phone | Relationship

BILLING & INSURANCE INFORMATION

Guarantor (person responsible for bill) **Same as patient** ☐

Name (Last, First, Middle) | Alias/Maiden

Birthdate / / | Soc Sec #: – – | ☐ Male ☐ Female | Relationship to patient

Address | Apt | City | State | Zip

Employer | Occupation | ☐ Retired | Primary Phone (cell/home) | Alternate Phone

Primary Insurance Provider:

Group: ID:

Subscriber: Same as patient ☐

Birthdate / / | Copay(s)

Soc Sec #: – –

Employer ☐ Retired | Relationship to patient

Secondary Insurance Provider:

Group: ID:

Subscriber: Same as patient ☐

Birthdate / / | Copay(s)

Soc Sec #: – –

Employer ☐ Retired | Relationship to patient

RELEASE OF MEDICAL INFORMATION

☐ Yes ☐ No I authorize the Physician or staff to leave medical information such as test results, medication information, or answers to questions on my answering system.

Phone: _____

☐ Yes ☐ No I authorize the Physician or staff to share my medical information such as test results, medication information, or answers to questions with:

☐ Spouse Name: _____

☐ Other Name: _____ Relationship: _____

INITIALS

CONSENT TO CARE: I consent to the plan of care proposed by the providers in this clinic. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my medical care and will make my wishes known.

INITIALS

NOTIFICATION OF RELEASE FOR PAYMENT: I understand that IFH will disclose any diagnosis and pertinent information to the extent required to assure payment from insurance companies and any liable third party payers. I understand that this disclosure, unless expressly limited by me in writing, will extend to all aspects of treatment including testing and/or treatment for HIV/AIDS, sexually transmitted diseases, substance abuse or mental health conditions.

INITIALS

FINANCIAL AGREEMENT: I understand co-payments are due at the time of service. I assign payment from my insurance directly to IFH. I understand I am financially responsible to IFH for the charges not paid by insurance and that those charges are due within 30 days of invoice. I understand that in addition to the bill from my provider I may also receive separate bills from the laboratory, radiology and other specialized services. If co-pays are not collected at the time of service, IFH may charge a $10 billing/administrative fee.

INITIALS

RECEIPT OF NOTICE OF HEALTH INFORMATION PRACTICES: I have received a copy of the IFH Notice of Health Information Practices which provides information about how my health information may be used and disclosed.

_____ Signature ☐ Signed by patient ☐ Signed by parent/guardian

Date _____

_____ Printed name of parent/guardian

_____ Relationship to patient

SEE OTHER SIDE