PATIENT INFORMATION

Date: _____

Patient Last Name	First Name	Date of Birth	Social Security Number	Male / Female Gender

Address	City	State	Zip Code	Ethnicity/Race (optional)	M, S, W, D Marital Status

Patient Occupation	Employer Name/Address	Primary Care Physician	Preferred Language

Legal Guardian's Name **	Address	Relationship	Gender	Date of Birth

REQUIRED FOR ALL CHILDREN

HealthCare Proxy++	Address	Relationship	Gender	Date of Birth

++IF FURTHER DEFINITION IS REQUIRED, PLEASE ASK ANY STAFF MEMBER.

I authorize the following methods of medical communication to myself:

☐ OK to mail medical information to my home

Primary Phone Number	Home / Cell / Work / Other ☐ OK to leave information on voicemail

Alternate Phone Number(s)	Home / Cell / Work / Other ☐ OK to leave information on voicemail

*Email Address(s)	☐ OK to send general messages

In consideration of confidentiality, I hereby authorize the release of medical information to:

Name	Relationship	Phone Number(s)	☐ OK to leave information on voicemail

In case of an emergency, please notify:

Name	Relationship	Phone Number(s)	☐ OK to leave information on voicemail

I understand that I must inform the office of any changes to the above information. I will be asked to review and verify this information annually. A new form must be completed with any changes or at a minimum of every two years. I will also provide an updated copy of my insurance card(s).

Signature	Date	Review Signature	Date

OVER →

Please give your insurance cards to the receptionist to be copied.

AUTHORIZATION TO RELEASE RECORDS

(General Consent – All patients must sign this release)

To process my medical claims for payment, I hereby authorize Fornance Physician Services, Inc., or their authorized agents, to release copies of my medical records and/or provided information regarding my physical or mental condition and treatment rendered to my insurance carrier and/or any agent acting on the insurance carrier's behalf. I understand that these records and/or information may include psychiatric/psychotherapy, mental health, HIV, and/or alcohol information or treatment records, and I authorize the release of such records and/or information to my insurance carrier and/or any agent acting on the insurance carrier's behalf.

I also authorize Fornance Physician Services, Inc. to release copies of my medical records to include the above-mentioned records and/or information to my primary care, family, or other treating physicians.

I understand that if this is a worker's compensation claim that the insurance carrier may employ a rehabilitation or consulting firm to handle my case. I authorize release of the above mentioned records and/or information to the workmen's compensation insurance and/or rehabilitation or consulting firm.

I hereby assign to Fornance Physician Services, Inc. all payments for medical services rendered to myself and/or my dependents, and I understand and agree that any services not covered by my insurance company are my responsibility to pay.

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR BUSINESS OFFICE.

INSURANCE AUTHORIZATION AND ASSIGNMENT: Name of Policy Holder _____

I request that payment of authorized Medicare/Other Insurance company benefits be made either to me or on my behalf to Fornance Physician Services, Inc. for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and CMS or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical health insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 112B of the Social Security Act and 31 U.S.C.3801-3812 provides penalties for withholding this information.)

Signature _____ Date _____

MEDICARE AND SUPPLEMENTAL INSURANCE

Name of Policy Holder - _____ Policy # _____

Request that payment of authorized medigap benefits be made either to me or on my behalf to the provider of service and (or) supplier of any services furnished to me by the provider of service and (or) supplier. I authorize any holder of Medicare information about me to release to (Medigap Insurer) _____ any information needed to determine these benefits payable for related services.

Signature _____ Date _____