DOUGLAS FAMILY MEDICINE
PATIENT INFORMATION

PATIENT INFORMATION

PATIENT NAME: LAST ________________________ FIRST ________________________ TODAY'S DATE _______________

SOCIAL SECURITY NUMBER _______-_______-_________ DATE OF BIRTH _______________ AGE ______ SEX M F

ADDRESS ____ APT# _________________________

CITY ____ STATE _____________________ ZIP ______________________

HOME PHONE _______________________ CELL/WORK ________________________ EMAIL _________________________

MARITAL STATUS SINGLE MARRIED DIVORCED WIDOWED DOMESTIC PARTNER

PRIMARY CARE DOCTOR ____ PHONE ______________________________

PREFERRED PHARMACY ____ PHONE ______________________________

MAIL ORDER PHARMACY ____ PHONE ______________________________

EMERGENCY CONTACT ____ PHONE ______________________________

RELATION _________________________

INSURANCE POLICY HOLDER

☐ Same as patient information

NAME ____ RELATIONSHIP _________________________________

ADDRESS ____

PHONE __________________ SOCIAL SECURITY NUMBER _______-______-________ DATE OF BIRTH _____________

HOW DID YOU HEAR ABOUT US?

REFERRING PHYSICIAN ____________________________________ FRIEND ___________________________________

INTERNET _______________________________ INSURANCE OTHER __________________________________

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY ____

POLICY/ID # ____ GROUP # ____

SECONDARY/AUTO/WORKERS COMP INSURANCE INFORMATION

SECONDARY AUTO WORKERS COMP

INSURANCE COMPANY NAME ____

POLICY/CLAIM # _______________________________________ GROUP # _______________________________________

INSURANCE AUTHORIZATION AND ASSIGNMENT

I acknowledge that I have read the HIPAA Notice of Privacy Practices and understand my rights concerning uses and disclosures of Protected Health Information.

PATIENT AND/OR INSURED SIGNATURE____ DATE ______________

It is a Medicare regulation that our office informs you that certain podiatric services may not be considered to be a medical necessity and therefore may not be reimbursed as a covered expense. It is the patient's responsibility to pay for services rendered if not covered by Medicare.

PATIENT AND/OR INSURED SIGNATURE____ DATE ______________

VOICE MAIL AUTHORIZATION

AT TIMES OUR OFFICE MAY NEED TO COMMUNICATE WITH YOU OUTSIDE OF THE OFFICE. WE WOULD LIKE TO CONTACT YOU IN THE MOST CONVENIENT MANNER WHILE STILL GUARDING YOUR PRIVACY. IF YOU WOULD LIKE US TO LEAVE A VOICE MAIL MESSAGE, OR A MESSAGE WITH SOMEONE OTHER THAN THE PATIENT PLEASE CHECK AND SIGN BELOW.

□ CLINICAL INFORMATION □ FINANCIAL INFORMATION

NAME ____ DATE __________________

SIGNATURE ____

FINANCIAL POLICY

We, at Douglas Family Medicine, are committed to providing you with the best possible care. If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

If you are self paying, full payment for service is due at the time the services are rendered. Insurance CO-PAYS are also due at the time of service. A $5.00 billing fee will be added if we have to bill you for a CO-PAY. We accept cash, check or credit card.

As a courtesy, we are happy to submit your insurance claim for you. However, please be aware that an insurance contract is between YOU and your INSURANCE COMPANY. We will make our best effort to collect from them, but if we are not successful, YOU are responsible for the unpaid balance. It is also the patient's responsibility to understand the insurance contract, including services covered, deductibles, co-pays and co-insurance included in your plan.

Your account is considered late if payment is not received 30 days past the statement date. Returned checks and balances older than 30 days are subject to a $25 late fee. All accounts 60 days past due will be sent to collections. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, please contact our office to arrange a payment plan.

If you have any questions concerning our financial policy, please don't hesitate to ask. We are here to help and look forward to continuing a good patient relationship with you.

PATIENT AND/OR INSURED SIGNATURE____ DATE ______________