Machen Family Medicine

Today's date:	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Home phone: ( )	Cell phone no: ( )

P.O. box:	City:	State:	ZIP Code:	Social Security no.:

Occupation:	Employer:	Employer phone no.:

Email Address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for bill:	Birth date:	Address (if different):	Home phone: ( )

Employer:	Employer address:	Employer phone: ( )

Name of primary insurance carrier (company):

Subscriber's name:	**Subscriber's S.S. no.:**	**Birth date:**	**Group no.:**	**Policy no.:**	**Effective Date:**

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no:	Policy no:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

HIPAA NOTICE OF PRIVACY PRACTICE

I have been given a copy of the HIPAA NOTICE OF PRIVACY PRACTICE.

→ ***Patient/Guardian signature*** ***Date***

RELEASE OF INFORMATION AUTHORIZATION

Personal health information CANNOT be released to anyone including your spouse without your consent. If you wish to authorize the release of your information please provide the **name** of the individual(s) below.

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→ ***Patient/Guardian signature*** ***Date***

FINANCIAL INFORMATION

We are happy to file the claim with your insurance carrier, however all charges are your responsibility. Any estimate by this office regarding insurance benefits is only a guideline. This office makes no guarantee of the insurance payment as estimated. It is the patient's responsibility to inform us of any changes to insurance or contact information.

In order to keep the cost of billing down, we ask that you pay your copays and deductibles at the time of service. There will be a $5.00 re-bill fee for any copays not paid at the time of services.

We accept cash, personal checks, Visa, Mastercard, Discover and American Express

There will be an additional fee of $35.00 for returned checks. There will also be a $20 late fee added to accounts 60 days pays due. Delinquent accounts (defined as 90 days past due with no payments made) will be reviewed for collections and an additional $20 fee will be applied to the account due to collection costs.

I have read and understand all stated financial policies of this office. I authorize Machen Family Medicine to release any medical information necessary to process my insurance claim. I also request that payments from insurance companies be made directly to the office. I also understand that I am financially responsible for any unpaid balance.

→ ***Patient/Guardian signature*** ***Date***

IN CASE OF EMERGENCY

Name of friend or relative we would contact in case of emergency:	Relation to patient:	Phone number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the doctor. I understand that I am financially responsible for any balance. I also authorize Machen Family Medicine or insurance company to release any information required to process my claims.

_____ _____

→ ***Patient/Guardian Signature*** **Date**