



Patient Information

Today's Date: _____

PATIENT INFORMATION

First Name: _____ M.I. _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Emergency Phone: _____

Date of Birth: _____ Sex: [] F [] M SSN: _____ Marital Status _____

Primary and/or Referring Physician Name: _____ Phone: _____

Patient's Employer Name: _____

Phone Number _____ ext _____

GUARANTOR/BILLING INFORMATION (If different than above)

First Name: _____ M.I. _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone _____

Email address _____

PRIMARY INSURANCE INFORMATION

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Relationship to patient: 1:Self 2:Spouse 3:Child SSN: _____

Employer of Insured _____ Insurance Company: _____

Policy Number: _____ Group Number: _____

Address of Insurance Company: _____ City: _____ State: _____ Zip Code: _____

Insurance Company Phone Number _____

SECONDARY INSURANCE INFORMATION

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Relationship to patient: 1:Self 2:Spouse 3:Child

Employer of Insured _____ Insurance Company: _____

Policy Number: _____ Group Number: _____

Address of Insurance Company: _____ City: _____ State: _____ Zip Code: _____

Insurance Company Phone Number _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE AND RECORD OF DISCLOSURE

The HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI).

I understand that as part of my health care, Seton family of Doctors originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment as well as plans my future care of treatment.

I understand that as part of Seton Family of Doctors treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity for the purposes stated above.

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a representative or my physician to mail, call or e-mail me with communication regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory and imaging results. I understand that I have the right to rescind this authorization at any time by notifying the Seton Family of Doctors in writing.

Patient/Parent Signature: _____ Date: _____

Print Name: _____ DOB: _____

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

I give permission to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices

I certify that I have received and read a copy of the Patient Information Privacy Policy.

Signature of Patient/Legal Guardian _____ Date: _____

(To be completed if patient refuses to sign Acknowledgement Notice)

Date: _____ Name of person providing notice: _____

Patient Authorizations

Our primary mission is to provide you with quality cost effective, medical care. It is important that we have a good understanding with our patients regarding financial responsibility. We hope this summary will be helpful in explaining your responsibility and the expectation in maintaining a positive Seton Family of Doctors and patient relationship. We encourage you to ask questions if you do not understand any areas of this document.

Please understand that financial responsibility for medical services rest between you and your health plan. While we are pleased to be of service to by filing your medical insurance for you, we are not responsible for any limitation in coverage that may be included in your plan.

- Co-payments and applicable deductibles are due at the time of service unless other arrangement have been made with our office
- If you are uninsured, or if you services being provided are not covered by your insurance, you will be expected to provide payment in full at the time that they are rendered.
- If you receive a payment from your insurance in error, please bring it along with any paperwork to our office.

1. Authorization to Release Information

I hereby authorize Seton Family of Doctors to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination and treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

2. Assignment of Insurance Benefits/Patient Financial Responsibility

I hereby authorize direct payment of my insurance benefits to the Seton Family of Doctors for services rendered to my dependents or me by Seton Family of Doctors providers or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsibly for any co-payment or balance due that Seton Family of Doctors is unable to collect from my insurance carrier for whatever reason.

3. Medicare/Medicaid/Insurance Benefits

I request that payment from Medicare/Medicaid or any other insurance carrier be made on my behalf to Seton Family of Doctors. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid and its agents or insurance company any information needed to determine these benefits payable for related services.

4. Lab/X-Ray/Diagnostic Services

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or diagnostic services. I also understand that I am financially responsible for any co-payment or balance due for these services if they are not reimbursed by my insurance for whatever reason.

5. Teaching Institution

I understand that Seton Family of Doctors includes teaching facilities and therefore, I may be attended to by students and residents of various disciplines and affiliated with various educational programs. I understand that I may request and receive information on the specific affiliation(s) of any particular healthcare provider I encounter during my care.

6. Consent to Treatment

I hereby consent to evaluation, testing and treatment as directed by my physician or his or her designee.

Patient/Guardian Signature

DOB

Date

Witness

Date