Family Practice Associates P.C.

Patient Information *(Acct #:) (Preferred Provider:)*

Name:	Social Security Number:	Date of Birth (DOB):	Sex:
Address:			
Primary Phone Number:	Work Phone Number:	Email Address:	
Mother's Maiden Name for State Immunization System:	Employer:		

Other

Preferred Language: (Please circle) English Spanish Other Refuse to Report
Race: (Please circle) American Indian/Alaskan Native Black/African American White Asian Other Refuse
Ethnicity: (Please circle) Hispanic/Latino Not Hispanic/Latino Refuse to Report

Account Information

Guarantor/Responsible Party:	Address:		Relationship to Patient:	
Home Phone Number:	Work Phone Number:	Cell Phone Number:	Date of Birth:	Sex:
Social Security Number:	Employer:	Employer Address:		

If Patient is Adult: Marital Status: (Please circle one) Single Married Divorced Widowed

Spouse Name:	Phone #:

If Patient is Child:

Father's Name:	Father's Phone:
Mother's Name:	Mother's Phone:

Policy Information

Primary Insurance Carrier Name:	Address:	
Subscriber:	Relationship to Patient:	DOB:
Policy ID#:	Group #:	

Secondary Insurance Carrier Name:	Address:	
Subscriber:	Relationship to Patient:	DOB:
Policy ID#:	Group #:	

Additional Information

Emergency Contact (other than spouse):

Name: Relationship: Phone:

Address: City/State: Zip:

FAMILY PRACTICE ASSOCIATES' POLICY IS PAYMENT FOR SERVICE ON DAY OF SERVICE

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the PATIENT/GUARANTOR is responsible for all fees regardless of insurance coverage. Family Practice Associates P.C. charges a $20.00 fee for checks returned due to nonsufficient funds.

I hereby authorize Family Practice Assocates to release any medical information necessary to process my claim (s). I permit a copy of this authorization to be used in place of the original. I thereby assign all medical/surgical benefits to which I am entitled to Family Practice Associates P.C. I certify that the information I have reported is correct.

Date: Signature:

Family Practice Associates P.C.

HIPAA Acknowledgement of Receipt and Patient Designation of Family Members and Friends

Family Practice Associates P.C. (FPA) takes patient privacy seriously. FPA personnel use and disclose patient health information only as permitted by FPA policies and applicable by law. Such policies and law permit FPA personnel to disclose a patient's health information to family members and friends designated by the patient/guarantor. This voluntary form allows you to designate the family members and friends to whom FPA personnel may disclose information about your health care, as well as the information that may be disclosed.

Patient's Name:	Patient's DOB:	Account #:
Guarantor's Name:	Mailing Address:	

[ ] I decline to have my medical information released to anyone not indicated in the release of information for insurance billing and medical necessity within the medical profession.

Names and relationships of persons to whom FPA may disclose your health information. Note: If you wish your medical information to be released to your SPOUSE, please include him/her, as well.

NAME	RELATIONSHIP	PHONE#

FPA personnel will disclose, as reasonably necessary, information about your health and health care to the person (s) you have designated above. This information may include, but is not limited to, appointment schedules and reminders; billing, insurance, and payment information; diagnosis and treatment, and information about your prescriptions. If you do not wish for FPA personnel to make certain disclosures, please describe the limitations:

_____

_____

_____

As described above, I hereby authorize and consent to FPA personnel disclosing information about my health and health care to the designated persons in accordance with FPA's policies and applicable law. **I also acknowledge that I have been provided a copy of Family Practice Associates P.C's Notice of Privacy Practices.**

Date: | Signature: _____

Please print name & relationship of patient if guarantor: _____

Office Note: [ ] Patient/Guarantor REFUSED to sign or decline. _____