New Patient Information

Name (Last)_____(First)_____(M.I.)_____

Address_____City_____State_____Zip_____

Marital Status_____ Sex: **M F** Employer_____

Birth Date_____Age_____ Social Security Number _____

Home Phone (___) _____Work (___) _____Cell (___)_____

Closest Relative not living with you _____ Phone (___)_____

Address_____ City_____State_____Zip_____

Person Responsible for Payment (complete only if different from above)

Name_____ Relationship_____ Employer_____

Home Phone (___) _____Work Phone (___)_____

Insurance Information

Name of Primary Insurance_____

Contract #_____ Group #_____Effective Date_____

Request for Confidential Handling of Health Information

Complete only if you want communications regarding your health care information sent to an alternate address or telephone other than listed above. I request that my provider handle my confidential health information as described below. All reasonable requests to receive communication of your health information by alternative means and/or locations will be granted. Please describe the alternative means below (e.g. US mail, telephone call, etc.) by which you prefer to receive your health information.

Alternate Address_____

Alternate Telephone_____ Alternate Telephone_____

Agreement

If your insurance company OR health plan requires pre-approval OR referral for your visit, it is your responsibility to obtain this referral or YOU will be personally responsible for the bill. I, the undersigned (patient or legal guardian), authorize medical treatment to be rendered by the provider and assume financial responsibility. In the event the account is not paid in full within 90 days*, the undersigned agrees to pay all costs of collection including reasonable attorney fees, and hereby waives all rights of exemption under the constitution and laws of the State of Florida. I also authorize the release of my medical records to my physicians and insurance carriers. If the provider has a contractual arrangement with your insurance carrier, the balance refers only to the amount that you are required to pay. Your signature below also indicates you have a right to access the HIPAA Notice Form: Notice of Policies and Practices to Protect the Privacy of your Health Information and agree to its terms and serves as an acknowledgement that you have the right to view the HIPAA Notice Form.

Signature of Patient or Responsible Party_____Date_____

If signed by a responsible party, describe that representative's authority to act for the patient_____