Parker Family Care™

Patient Information Form

This is a legal document.

Legal First Name:_____ Last Name: _____ Middle Initial:___

SSN: _____-_____-_____ Birth Date: _____ Sex: M F

Race: Caucasian | African American | Asian | Hispanic or Latino
American Indian / Alaska Native | Native Hawaiian / Pacific Islander | Patient Declined

Ethnicity: Hispanic or Latino | Not Hispanic or Latino | Patient Declined

Address: _____

City: _____ State: _____ Zip Code: _____ Marital Status: _____

Home Phone: _____ Cell Phone: _____

Email we may contact you with: _____

Employer: _____ Work Phone: _____

If using a phone, do you have a preferred time you would like us to call you? _____

Do you want phone reminders to be confidential? Yes No

Can a message be left on voice mail? Yes No

Which phone would you prefer **voicemail** to be left on: Home Cell

Can a message be left with family? Yes No

If yes, list the names:

_____

If by mail, indicate address if different than home: _____

_____

Emergency Contact:

Name: _____ Relationship to you: _____

Home phone number: _____ Cell phone number: _____

Is there a specific provider at our office would you prefer to be scheduled with: _____

Is there someone we can thank for your referral (another office, family member, coworker, another patient)?

_____

Guarantor / Person Responsible for Account (if other than yourself):

Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Birth Date: _____

Relationship to You: _____ SSN: _____-_____-_____

Primary Insurance information:

Insurance company name: _____

Identification number:_____ Group number: _____

Policy holder's name:_____

Policy holder's DOB:_____

Policy holder's address (if different than above):_____

Relationship to Patient: _____

Secondary Insurance information:

Insurance company name: _____

Identification number:_____ Group number: _____

Policy holder's name:_____

Policy holder's DOB:_____

Policy holder's address (if different than above):_____

Relationship to Patient: _____

____ Initial. Financial: I understand that all copays and past due balances are due at the time of my visit. I will pay my/family balance in full in 30 days. If I am unable to do so, it is my responsibility to contact the PFC office to make arrangements to pay my balance with an EFT payment plan. If I choose not to pay my balance or contact the office within 60 days, I understand my account may be turned over to an outside collection agency. $20 late co-pay fee may be billed.

____ **Initial. Insurance:** I have provided current insurance information and will continue to inform the office when I have an insurance or address change.

____ **Initial.** If you have Advanced Directives, please notify the medical staff and provide PFC with a copy.

____Initial. Assignment of Benefits: I authorize payment of medical benefits to Parker Family Care for services rendered. In addition, I authorize Parker Family Care to release any information that they are requested to release in order to obtain payment on my behalf.

____ **Initial. Cancellation**. A $50 charge will be assessed for office visits that I do not appear for or which I cancel less than 24 hours prior to appointment time. A $100 charge will be assessed for physicals and CIMT that I do not appear for or cancel less than 24 hours before the scheduled appointment time.

_____**Initial. Establish care policy:** I understand that Parker Family Care has a policy that you see a physician or physician assistant for the first time to establish care. This visit will NOT be coded as preventative and I am responsible for whatever my insurance does not cover, i.e. copay, coinsurance, deductible.

_____**Initial. E-mail Consent:** I understand that the e-mail address I have provided may be used to send me appointment confirmations or other electronic communication related to Parker Family Care. I have provided the e-mail I wish to receive such confidential information at and understand that Parker Family Care cannot be held liable for who reads my e-mails. Anyone I have given my e-mail login information to, such as family members, may receive these e-mails.

I request the following restrictions to the use or disclosure of my health information:

_____

_____

Please provide your signature below to indicate that you have read the above consent and have reviewed the Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Represent Witness

_____ _____

Date Effective Date