CapitalMedicalClinic

Serving Austin since 1934

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Address: _____**Apt#:**_____**City:**_____**State:**_____**Zip:**_____

Home#:_____**Work#:**_____ **Cell#:**_____ **Email:** _____

Age: _____ **Sex:** ○**M** ○**F** **Date of Birth:** _____ **Marital Status:**_____ **SS#:**_____

Ethnicity: ☐ **African American** ☐ **American Indian** ☐ **Asian** ☐ **Caucasian/White** ☐ **Hawaiian** ☐ **Hispanic/Latino** ☐ **Other**

Race (circle one): ☐ **White** ☐ **Hispanic** ☐ **Black or African American** ☐ **Asian** ☐ **Chinese** ☐ **Filipino** ☐ **Japanese** ☐ **Multiracial** ☐ **Other** ☐ **American Indian or Alaska Native** ☐ **Native Hawaiian or Other Pacific Islander** ☐ **Native American** ☐ **Patient Declined**

Preferred Language: _____

Employer's Name: _____ **Occupation:** _____

Address: _____ **City:** _____ **Zip:**_____

Spouse Name: _____**Home#**_____**Work#**_____

Emergency Contact: _____**Relationship:**_____**Phone#:**_____

Who referred you? (please circle) FAMILY FRIEND PHYSICIAN REFERRAL ADVERTISEMENT WEBSITE
Name of person or physician referring you:

INSURANCE INFORMATION OF POLICY HOLDER

Primary Insurance: _____**Address:** _____**State/Zip:** _____**Phone#:**_____

ID#:_____ **Group#:**_____ **Policy Holder Employer:** _____

Policy Holder: _____**Date of Birth:**_____ **SS#:**_____**Relationship:**_____

Secondary Insurance:_____**Address:**_____**State/Zip:**_____**Phone#:**_____

ID#:_____ **Group#:**_____ **Policy Holder Employer:**_____

Policy Holder:_____**Date of Birth:**_____ **SS#:**_____**Relationship:**_____

Patient Consent to Share Personal Health Information

I hereby authorize Capital Medical Clinic to share my personal health information including financial information with named persons below until further written notice from me:

Name:_____ **Relationship to Patient:**_____

Name:_____ **Relationship to Patient:**_____

Name:_____ **Relationship to Patient:**_____

Capital Medical Clinic reserves the right to charge $50.00 for any appointment cancelled without 24hr-advanced notice and there is a $25.00 charge to your account for each returned check.

Assignment and Authorization of Benefits

I hereby give authorization for payment of insurance benefits to be made directly to Capital Medical Clinic, LLP for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this Agreement is as valid as the original.

Acknowledgement of Review of Notice of Privacy Practices

I have been given the opportunity to review this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Authorization for Voicemail Usage for PHI

I hereby give permission to leave a message on my voicemail concerning my personal health information ☐ (decline option)

Authorization to obtain Pharmacy History

I hereby authorize Capital Medical Clinic to obtain my Medication History from my pharmacy/pharmacies for the purpose of Continued Medical Treatment. This will help the physician to have a more current and complete list of medications to assist in efficiently caring for your medical needs.

Pharmacy Name and address: _____

Pharmacy Phone #: _____

Signature: _____ Date:_____ Witness:_____Date:_____

(If filling in the information via a computer, please print the form and then sign it.)