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:

White ◯ **Hispanic** ◯ **Black/African American** ◯ **Asian** ◯ **Chinese** ◯ **Filipino** ◯ **Japanese** ◯ **Multiracial** ◯ **Other** ◯

American Indian / Alaska Native ◯ **Native Hawaiian /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? **FAMILY** ◯ **FRIEND** ◯ **PHYSICIAN REFERRAL** ◯ **ADVERTISEMENT** ◯ **WEBSITE** ◯

Name of person or physician referring you:

INSURANCE INFORMATION OF POLICY HOLDER

Primary Insurance:_____

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

CAPITAL MEDICAL CLINIC
FINANCIAL AND PRIVACY POLICY ACKNOWLEDGEMENT

_____ _____

Printed Patient Name Date of Birth

As a service to our patients, we will file insurance claims to the companies we are contracted with for the services provided. Itemized bills will be provided to you for those services upon request. The filing of insurance does NOT release the patient from responsibility of incurred charges for services which have been provided. All fees including co-pays, deductibles and non-covered services are due and payable on the date of service unless other payment arrangements have been made in advance. We accept Cash, Personal check, MasterCard, Visa, Discover and American Express.

If you have health insurance, you are responsible to:

- Verify with your insurance carrier that services performed or proposed by our office are covered under your individual plan. We suggest you contact the customer service telephone number listed on your insurance card prior to being seen in our office.
- It is your responsibility to know what your policy covers and what it does not. We cannot quote your benefits. Any disputes about payment must be resolved between you and your insurance company.
- Failure to provide accurate insurance information within 15 days from the date of service will result in the balance becoming your responsibility.
- Obtain any authorizations or referrals required by your insurance carrier.
- Pay our office for any deductible, co-payment or non-covered charges.

Unless specific arrangements have been made in advance for an extension of time, charges for services not covered by insurance are due upon receipt of a patient statement. Statements showing the status of your account are mailed monthly. If you are unable to make payment when due, please contact our office by calling (512) 454-5171 as soon as you receive our statement. Accounts which are not paid within 90 days of statement receipt are subject to placement with an outside collection agency.

If you do not have health insurance coverage;

- Payment for the office visit and all diagnostic services is expected the day the service is provided.

Assignment and Authorization of Benefits

I hereby give authorization for payment of insurance benefits to be made directly to Capital Medical Clinic 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.

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:**_____

Authorization for Voicemail Usage for PHI

I hereby give permission to leave a message on my voicemail or answering machine concerning my personal health information. Please initial

_____

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.

I have read and understand Capital Medical Clinic's financial and privacy policies and I agree to be bound by its terms. I also understand and agree that such terms may be amended by Capital Medical Clinic at any time.

_____ _____

Patient's Signature Date