REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name: _____ Today's Date___/___/___

Do you give our office permission to discuss your medical information with family members ***(ex: spouse, children, parent, sibling, friend, or doctor)?***

❑ YES ❑ NO If yes, please provide their names and phone numbers below.

Name: _____ Relationship: _____

Phone # (day): (___) _____ Phone # (evening): (___) _____

Name: _____ Relationship: _____

Phone # (day): (___) _____ Phone # (evening): (___) _____

EMERGENCY CONTACT INFORMATION:
Must live in a separate residence or have a different phone number.

In case of Emergency, who should be notified? _____ Phone: ( ) _____

Relationship to patient: _____

May we leave personal medical information on your answering machine or cell phone?

❑ YES ❑ NO

May we e-mail personal medical information to you? ❑ YES ❑ NO

E-mail address: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices).

Patient or Responsible Party Signature _____ Date ___/___/___

Print Patient or Responsible Party Name _____

RECEIPT OF FINANCIAL POLICY:

Your signature below signifies permission to bill your insurance, your understanding of our financial policy, and your responsibility regarding charges incurred in this office.

Patient or Responsible Party Signature _____ Date ___/___/___

Print Patient or Responsible Party Name _____ D.O.B. _____