**PATIENT INFORMATION**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *By providing your email address, you consent to our Email Privacy Policy*

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

Employer Work Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Responsible Party: Self ( ) Spouse ( ) Dependent ( ) Other ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Name (if different from patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Responsible Party’s address is different than above, please fill in address:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

**How did you hear about us?**

( ) Building Signage ( ) Family/Friend/Referral ( ) Internet/Online Search ( ) Print Advertising ( ) Radio ( ) Event

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT FOR TREATMENT + FINANCIAL OBLIGATION + USE OF PROTECTED HEALTH INFORMATION**

I hereby consent to medical evaluations, testing, and/or treatment provided by the staff of this medical facility. I authorize information and subsequent visits to be relayed verbally, written, or faxed to my family doctor, commercial insurance company, and/or employer, if applicable.

I understand that even though I may have an insurance claim pending, I ultimately remain responsible for the account balance. Patient Plus does not accept responsibility for collecting an insurance claim or for negotiating a disputed claim. In the event of non-payment, I will be responsible for any collection and legal fees associated with the balance due. If I decline to swipe my card this visit, I understand it is my responsibility for following visits to notify the Patient Plus employee who is about to swipe my card if I still wish to decline.

I acknowledge that upon request I can receive the Notice of Privacy Practices and the Notice of Nondiscrimination of Patient Rights and Responsibilities.

I have read this policy and agree to the terms within for services rendered.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_