FAMILY FIRST MEDICINE, LLC

Urgent & Family Health Care

Sebrina Butts, CRNP/FNP **Dedra Capps, CRNP/FNP**

PATIENT INFORMATION FORM

Account No.: ______________________ Today's Date: ______________

Patient's Name: ______________________ Home Telephone: ______________

Address: ______________________ Mobile Telephone: ______________

City, State, Zip: ______________________

Date of Birth: ______________ Sex: ______ Social Security No.: ______________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer: ______________________ Work Telephone: ______________

Address: ______________________

Occupation: ______________ Retired: ☐ Yes ☐ No Disabled: ☐ Yes ☐ No

Spouse's Name: ______________________ Date of Birth: ______________

Social Security #: ______________________ Work Telephone: ______________

Employer: ______________________

Person To Contact In Case Of Emergency **(Not Living With You):** Relationship ______________

Name: ______________________ Telephone: ______________

May We Call You At Work With Test Results? ☐ Yes ☐ No

May We Leave A Message With Your Spouse? ☐ Yes ☐ No

May We Contact You By Email, If We Are Unable To Reach You By Phone? ☐ Yes ☐ No

Email Address: ______________________

COMPLETE THIS SECTION IF PATIENT IS A MINOR OR STUDENT

Person Responsible For Bill: ______________________

Father's Name: ______________________

Date of Birth: ______________________ Social Security #.: ______________

Address: ______________________ Home Telephone: ______________

Employer: ______________________

Address: ______________________ Work Telephone: ______________

Mother's Name: ______________________

Date of Birth: ______________________ Social Security #.: ______________

Address: ______________________ Home Telephone: ______________

Employer: ______________________

Address: ______________________ Work Telephone: ______________

INSURANCE INFORMATION

Primary: ______________________ Copay Amount: $: ______________

Secondary: ______________________

Please Give Receptionist Your Insurance Cards To Copy

IMPORTANT: Please Read And Sign The Back Of This Form

EXPLANATION OF COLLECTION AND CHARGES

(A LIST OF CHARGES WILL BE FURNISHED UPON REQUEST)

Family First Medicine, LLC is committed to the highest level of medical care and innovative patient-centered services. In order to meet this standard and cover the cost of a growing multitude of non-covered and excluded administrative expenses. Family First Medicine, LLC charges a $10 fee per page for additional paper work. This fee allows us to offer many administrative services not-covered by insurance. This fee is used to compensate staff for time spent completing many standard documents such as and not limited to: Family Medical Leave Act papers, return to work forms, immunization records, school/camp/sports forms, pharmacy forms including change requests and special authorizations.

PAYMENT POLICY

PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED. THE PATIENT IS RESPONSIBLE FOR PAYMENT, NOT THE INSURANCE COMPANY. WE WILL BE GLAD TO ASSIST THE PATIENT BY FILING INSURANCE.

AGREEMENT TO BE PAY

I agree to pay for services rendered by Family First Medicine, LLC. I agree to pay the attorney fees and collection cost in the event it becomes neccessary to retain such services for collection of my account.

AGREEMENT TO BE PHOTOGRAPHED

I agree to allow Family First Medicine, LLC to take a photograph to be saved in chart for identity purpose only to help prevent fraud. This would also help distinguish between patients having the identical names.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of medical information and records concerning my treatment to Medicare, Medicaid and/or other insurance companies and assign my claim for medical benefits to Family First Medicine, LLC to the extent permitted under applicable law or insurance agreements. I agree to allow Family First Medicine, LLC to request and release my medical records from and to other physicians or medical institutions as it deems necessary for my medical care and I further authorize the release of my medical records by such parties for such purpose. I release Family First Medicine, LLC from all legal responsibility or liability that may arise from the above authorizations and agreements. This authorization will remain in effect unless cancelled by my request.

CONSENT TO TREATMENT

I authorize the physicians of Family First Medicine, LLC, their associates, nurses, technical assistants and other health care providers under their direction to provide diagnostic evaluation and treatment. I understand that no guarantee has or will be made to me regarding any possible result or cure based on my examination and/or treatment.

Patient Signature: ______________________________ Date: __________

Witness Signature: ______________________________ Date: __________

Family First Medicine

504 McCurdy Ave S Ste 6 Rainsville, AL 35986

NOTICE OF POSSIBLE NON-COVERED SERVICES WAIVER

I ______________________ understand that some services may not be eligible for benefits by my health insurance provider and I will be held responsible for these charges. I understand that my health insurance coverage has certain restrictions and limitations, such as non-covered service guidelines: (including but not limited to , Immunizations, Injections, Blood Work, Durable Medical Equipment, Holter Monitor, X-Rays, Minor Procedures or Physicals)

By signing this form I understand that I am agreeing in advance to receive services and will pay for the services rendered IF my insurance denies payment due to services not covered.

____

(Patient Printed Name)

______________________________ ____________________

(Patient Signature) (Date)

Patient Acknowledgement
Receipt of Privacy Notice

I, ____ hereby affirm that I have received a copy of the *Notice of Privacy Practices* from FAMILY FIRST MEDICINE Under federal law 104-191, also known as HIPAA. I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the *Notice*, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

____
Patient Name (print)

____
Signature of Patient or Personal Representative

____
Name of Patient or Personal Representative (print)

____
Date

____
Description of Personal Representative's Authority (if applicable)

Name/Identification of person(s) to whom protected health information can be disclosed:

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▼▼▼▼ FOR OFFICE USE ONLY ▼▼▼▼

Received by:	
Date Received:	Time Received:
Patient Declined ☐	
Staff Signature:	