Conner Family Health Clinic, PLLC

Welcome to our practice? Please help us serve you better by taking a few minutes to provide the following information:

Patient Information

Patient Name	Date of Birth	Social Security #	Primary Language	Sex
	- -	- -		□ Male □ Female

Address & Apt. Number	City	State & Zip

Home Phone	Cell Phone	Work Phone	Email Address
- -	- -	- -	

Race	Ethnicity	Marital Status
□African American □Asian □Caucasian □Hispanic □Other	□ Hispanic or Latino □ Non-Hispanic or Latino	□ Divorced □ Married □ Separated □ Single □Unknown □ Widowed

Responsible Party Information: (if guarantor is different from patient)

Name	Relationship to Patient	Home Phone	Cell Phone
		- -	- -

Address	Apt. #	City	State & Zip

Emergency Contact Information:

Name	Relationship to Patient	Phone Number:

Financial Responsibility and Assignment of Insurance Benefits:

I guarantee payment to Conner Family Health Clinic, PLLC of all charges for services provided to the patient. I understand that I am personally responsible for all charges not covered by insurance. I authorize payment of surgical and medical benefits which would otherwise be payable to me, to Conner Family Health Clinic for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVIII, and/or XIX or Social Security Act is correct. If the patient is a child of divorced parents, it is the policy of the clinic that the parent bringing the child in for treatment is financially responsible for that appointment, unless otherwise stated in court documents. **I also acknowledge that I have been informed of Conner Family Health Clinic's No-Show/late cancellation policy. I understand that if I fail to show for a scheduled appointment for fail to give 24 hours notice of cancellation that I may be charged a $25.00 fee.**

Consent for Healthcare and Release of Medical Information:

I voluntarily consent to healthcare treatment from the physician and staff at this clinic. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the result of treatments or examination by caregivers. I consent to the use and disclosure of protected health information about me for treatment, payment, and healthcare operations. I have read this form and have had the opportunity to ask questions and my questions have been answered.

Signature of Patient or Authorized Person: _____ Date: _____

Signature of Insured Party or Authorized Financial Guarantor, if different from above: _____