**Patient Information Sheet**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_ Sex: \_\_\_\_\_M \_\_\_\_\_\_F

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.com

Cell Phone: (\_\_\_\_\_\_\_\_\_)-\_\_\_\_\_\_\_\_ -\_\_\_\_\_\_\_\_\_ Home Phone: (\_\_\_\_\_\_\_\_\_)-\_\_\_\_\_\_\_\_ -\_\_\_\_\_\_\_\_\_

Preferred method of contact for appointment reminders: \_\_\_\_\_Phone \_\_\_\_\_Email \_\_\_\_\_Text

**Responsible Party for Billing**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ SS# \_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_

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

**Authorization to Release Medical Information**

\_\_\_\_\_\_\_ **YES**, **I GIVE MY PERMISSION** to leave my health-related information on my voice mail.

\_\_\_\_\_\_\_ **NO, DO NOT** leave my health-related information on my answering machine or voice mail.

By HIPAA standards, we are not allowed to discuss your health information with anyone without your written consent. **Please check one.**

\_\_\_\_\_\_\_ Information is not to be released to anyone.

\_\_\_\_\_\_\_Information may be released to the following:

Please indicate who you authorize WNC Family Medical Center to discuss your health information with.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name Phone # Relationship**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name Phone # Relationship**

**HIPAA Acknowledgement**

I have been given a copy of WNC Family Medical Center’s Notice of Privacy Practices; version effective 09/01/2013. I consent to the uses and disclosures of my health information as outlined in the Notice.

Insurance/Medicare Authorization for Payment

I authorize that payment be made to WNC Family Medical Center for all medical benefits entitled to me. I understand that I’m financially responsible for charges not covered by assignment and/or remaining balances. I give my permission to WNC Family Medical Center to provide health care to myself or my dependent.

**I am signing below to verify that the above information is factual and true to the best of my knowledge. I am also authorizing the HIPAA Acknowledgement and Insurance/Medicare Authorization for Payment.**

**SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_**