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:** _____/_____/_____