Patient Information Sheet

First Name: _____ Middle: _____Last Name: _____

Birthdate: _____/_____/_____ Social Security #: _____-_____-_____ Sex: _____M _____F

Mailing Address: _____ City: _____

State: _____ Zip: _____ Email: _____.com

Home Phone: (_____)-_____-_____ Cell Phone: (_____)-_____ -_____

***Language:* ___English ___Spanish ___Other *Marital Status*: ___Single ___ Married ___ Divorced __Widow**

***Race/Ethnicity:* ___Caucasian ___ Hispanic ___African American___ Asian ___Other**

Responsible Party for Billing

___Self ___Spouse ___Parent ___Guardian

Full Name: _____Birthdate: ____/____/_____ SS# _____-_____-_____

Address: _____ City: _____ State: ____ Zip: ____

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.

HIPAA Acknowledgement and Consent

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.

By HIPAA standards we are not allowed to leave any information related to your health on your voicemail or answering machine. However if you feel your message retrieval system is safe and your information is protected, you must give us written consent to allow us to leave information on your messaging systems.

Please **INITIAL** one of the options below.

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

_____

Name **Phone #** **Relationship**

_____

Name **Phone #** **Relationship**

I am signing below to authorize the Insurance/Medicare Authorization for Payment and the HIPAA Acknowledgement and Consent section.

SIGNATURE _____Date: _____/_____/_____