

PATIENT INFORMATION

We are a family medicine clinic offering direct primary care services, where our goal is to promote patient health through convenience and time management. We do not accept insurance of any kind. Additionally, Dr. Bryan Stephens D.O. provides the following:
prescribes controlled substances only when clinically necessary

Office Visits:

New Patients/extended \$125

Established Patient \$95

Follow-Up Visit \$60

3% cash discount

hormone replacement therapy

weight loss services

PATIENT INFORMATION

Full Name :

(FIRST,

MIDDLE,

LAST)

Date of Birth :

____/____/____

Gender :

☐

Male

☐

Female

Age: _____

SSN#: _____

DL #: _____

Address :

(STREET,

CITY,

STATE,

ZIP,

Phone Number :

E-Mail :

Preferred Pharmacy :

(NAME,

CITY,

PHONE)

GUARDIAN / SPOUSE INFORMATION

Full Name :

(FIRST,

MIDDLE,

LAST)

Date of Birth :

____/____/____

Gender :

☐

Male

☐

Female

Age: _____

SSN#: _____

DL #: _____

Address :

(STREET,

CITY,

STATE,

ZIP,

Phone Number :

E-Mail :

Emergency Contact Name: _____

Phone Number : _____

Patient Signature: _____

Date: _____

(PATIENT OR PARENT/GUARDIAN OF MINOR PATIENT)

PRIVATE PAY AGREEMENT

I UNDERSTAND THAT MOHAWK FAMILY MEDICINE IS ACCEPTING ME AS A PRIVATE PAY PATIENT. I WILL BE RESPONSIBLE FOR ANY SERVICES I RECEIVE. THE PROVIDER **WILL NOT** FILE A CLAIM WITH MEDICAID OR ANY PRIVATE INSURANCE FOR SERVICE PROVIDED TO ME.

PAYMENT IS DUE AT THE TIME OF SERVICES

Patient Signature:

Date:

CONSENT TO COMMUNICATE VIA EMAIL & TEXT MESSAGE

PATIENT CONSENT FOR EMAIL AND TEXT MESSAGE COMMUNICATION

Here at **Mohawk Family Medicine** our main communication is through phone call and or text messaging. Patient Privacy is important to us, and Mohawk Family Medicine would like to communicate with you regarding confirming appointments, referral appointments and return for lab results appointments, which means we need your consent.

Email and text communication will never be used for urgent communication.

Should I wish to withdraw consent I accept that I must give at least 5 working days' notice in writing quoting the email and phone number listed below. I will advise the practice if I change my phone number and understand that a new consent form is required.

I _____ give Mohawk Family Medicine
consent to contact me via:

☐ Email and Text	Email: _____
☐ Email Only	
☐ Text Only	Cell Phone: _____
☐ Neither	

Patient Name: **DOB:**

Patient Signature: **Date:**

Parent of Guradian signing for a child of 17 years old and under, please state your relationship:

Consent must be signed by actual patient or legal guardian.

RELEASE OF PATIENT INFORMATION CONSENT FORM

I hereby authorize Mohawk Family Medicine to release any of my medical information to
the following person / persons:

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____

Print Name:

DOB:

Patient Signature:

Date:

Witness Signature:

DATE:

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Print Name:

Date:

**Patient Signature or
Personal Representative:**

Date:

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Privacy Notice, but was unable to do so as documented below.

Date:

Initials:

Reason: _____