FOUNTAINS OF HEALTH, LLC

7 Taggart Drive, Suite E
Nashua, NH 03060
603-943-8923 (Telephone)
603-943-8906 (Fax)

___ New Patient
___ Existing Patient

Existing Patient: Revise all information that has changed since your last visit

Date ___/___/____ Email Address: _____ Home phone:_____ Work Phone:_____

Last Name_____First Name_____MI___ Cell Phone: _____

Street Address: _____ Mailing Address_____

City: _____ State _____ Zip_____

Gender: Male___ Female___ SSN: _____ - _____- _____ Birthdate ____/____/_____

Circle One: Married - Single - Partnered – Widowed Name of Partner/Spouse/Significant Other _____

Patient Employed by: _____

Business Address_____

Business Phone: _____ Occupation _____

Name of Spouse/Responsible Party (If patient is minor): _____
Last First MI

Spouse/Responsible party Employed by: _____

Business Address: _____

Business Phone: _____ Occupation _____

Responsible Party/Spouse SSN: _____-_____-_____

Do you have medical Insurance? Circle One: No Yes If yes, please fill in the following information:

Name of Primary Insurance: _____ ID # _____ Group # _____

*Subscriber's Name: _____ *Birth-date: ____/____/____

Insurance Address _____

Name of Secondary Insurance: _____ ID # _____ Group # _____

*Subscriber's Name: _____ *Birth-date: ____/____/____

Insurance Address _____

*This information is required by HIPPA

In case of an emergency, who should be notified? _____

FOUNTAINS OF HEALTH, LLC

Relationship _____Phone: _____

Preferred Pharmacy: _____ How did you hear about us? _____

Assignment of Insurance Benefits

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and even claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____ hereby authorize_____
(Name of Insured) (Name of Insurance Company)

to pay and hereby assign directly to FOUNTAINS OF HEALTH, LLC all benefits, if any, otherwise payable to me for his/her

services as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to _FOUNTAINS OF HEALTH, LLC___
(Provider's Name)

will be credited to my account, in accordance with the above said assignment.

_____ _____
(Authorized Signature of Subscriber) (Date)

Medicare Authorization

IF YOU ARE COVERED BY MEDICARE, PLEASE SIGN AND DATE BELOW

I request payment of authorized Medicare benefits be made either to me or on my behalf to FOUNTAINS OF HEALTH, LLC, are for any services furnished to me by [practice name]. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the health care provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services, Co-Insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Signature of Beneficiary Date

Financial Policy

I have read and understand the financial policies of [Practice Name]. By my signature I agree to the terms outlined in the financial policies.

_____ _____
Signature Date

Consent for Treatment

I (or my legal guardian/parent) authorize FOUNTAINS OF HEALTH, LLC to provide medical care reasonable by today's standards.

_____ _____

Signature of Patient/Legal Guardian Date