Family Clinic of New Albany

Please Print

Full Name: ___________________________________ **Date of Birth**: ______________

Social Security Number: __________________ Sex: ______ Race: _____

Mailing Address (city, state, zip):

____

Home Phone: _________________ **Cell Phone**: ____________________ Alt Phone: ___________

Marital Status: _______ Spouse's Name: ____________________ Spouse's Phone: ____________

Emergency Contact (REQUIRED):_____________________ Phone: _____________

How were you referred to this practice: _______________________________________

Employer: ______________________________ Contact Name: __________________

Contact Number: ________________________ Occupation: _____________________

Insurance Information (Policy Holder information required to bill insurance)

Primary Insurance:_____________________ Name of Policy Holder:_______________

Relationship to Policy Holder:_____________ Birth date of Policy Holder:___________

Secondary Insurance:__________________ Name of Policy Holder:_______________

Relationship to Policy Holder:_______________ Birth date of Policy Holder:_________

Authorization Agreement:

I hereby irrevocably authorize Family Clinic of New Albany, Inc. for the purpose of billing, to furnish insurance carriers concerning any illness/accident for which I am treated in this clinic, and I hereby irrevocably assign to Family Clinic of New Albany, Inc. all payments for medical services rendered. I understand that I am financially responsible for charges whether or not covered by insurance, and if I fail to pay any amount due, I will be responsible for all collection fees, court costs, attorney fees, and any other charges incurred in the collection of the balance due.

I authorize Family Clinic of New Albany, Inc. to initiate a complaint to the insurance commissioner for any reason on my behalf.

I consent to care encompassing diagnostic procedures and medical treatment by any physician, nurse practitioner, or other medical professionals in this office, as my health care provider deems necessary. I understand that I will be billed for services performed. I acknowledge that no guarantees have been made as to the results of treatment or examinations. I further agree not to file any claims against this clinic or any health care provider employed by Family Clinic of New Albany, Inc. I accept their decisions in full faith that they are providing proper treatment to the best of his/her knowledge and medical training.

I give permission for my work/school excuse to be faxed to the appropriate facility when necessary.

I acknowledge that I have received, read, and understand the "Notice of Privacy Practice" given to me by this clinic. I understand it is my responsibility to notify the office personnel of the clinic if I wish to amend this "Notice of Privacy Practice."

Signature of Patient of Responsible Party:____________________________

Date:_____________

Responsible Party Information Form for Minors

Family Clinic of New Albany

Name of Child(ren):____

Legal Custodian of Child(ren):____

Guardian/Mother

Name:______________________________ Date of Birth:__________ Social:______________

Address:____

Employer:_____________________________ Work number:_____________________

Guardian/Father

Name:______________________________ Date of Birth:__________ Social:______________

Address:____

Employer:_____________________________ Work number:_____________________

I, ____________________, give permission to the following people to bring my children to the clinic and seek whatever medical care that is determined to be needed by the practitioner. I understand I will not be contacted by the clinic prior to my children being treated. I also understand this permission will remain in effect until I revoke it in writing.

Name	Relationship to Child	Contact Information

Signature of Guardian: _______________________________

Date: ______________

FCNA Witness: ________________________________

Patient Privacy Agreement

Family Clinic of New Albany

The following people have permission to discuss/review my healthcare information:

Name	Relationship	Contact Information

I understand that only those individuals listed above or otherwise covered by HIPAA law will be able to contact my doctor's office for information regarding my healthcare. I understand that these names must be changed in writing if I no longer wish for someone to be on my patient privacy. I will not hold Family Clinic of New Albany responsible for any problems this may cause as they are following my request.

Signature of Patient of Responsible Party:_________________________

Date:________________

OR

I understand that by not listing anyone above that no one will be able to call the clinic in my place including but not limited to if I were hospitalized or otherwise unable to call myself. I am willing to take this risk and will not hold accountable Family Clinic of New Albany for any problems this may cause as they are following my request.

Signature of Patient of Responsible Party:_________________________

Date:________________