



TRANQUILITY
HOUSECALL SERVICES

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Patient Consent and Information Form

Patient Information

Name: _____ DOB: _____ SSN: _____

Gender Identification: M ___ F ___ Other ___ Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

Next of Kin Contact Name: _____ Ph: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: () _____ - _____ Secondary Phone: () _____ - _____

Primary Care Physician: _____

Phone: _____ Fax: _____ Last Seen: _____

Insurance Information

Primary Insurance Carrier: _____

Policy Number: _____ Group Number: _____ Effective Date: _____

THIRD PARTY CONSENT

I understand and agree that, regardless of insurance status, I am responsible for the balance on this account for any professional services rendered. I certify that the information provided is true and correct. I will notify Tranquility House Calls LLC of any changes in the above information, including insurance coverage, in a timely manner.

Initial: _____

PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have been provided access to Tranquility House Calls, LLC's Notice of Privacy Practices (NPP). I understand I can obtain a copy of the full NPP from the front office and that I may ask to speak with the Privacy Officer if I have any questions.

Initial: _____

AUTHORIZATION TO RELEASE INFORMATION

I authorize Tranquility House Calls, LLC to communicate with my insurance company to coordinate treatment, facilitate quality of care, and obtain reimbursement. By not signing consent, I agree to full payment at the time of service.

Initial: _____

Patient Acknowledgment

Patient Name: _____ Date: _____

Signature: _____ Date: _____