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MacKenzie Cheek, NP-C • Brad Jones, FNP • Austin Darbyshire, FNP

Full Name _____Today's Date _____

Street Address _____

City _____State _____Zip _____

Home Phone (_____) ____-_____Work (_____) ____-_____Cell (_____)_____- _____

Date of Birth _____/_____/_____Last 4 digits of social security number _____

Email _____

Sex _____Male _____Female Marital Status _____Single _____Married _____Divorced

PERSON RESPONSIBLE FOR PAYMENT

Name _____Relationship _____

Address _____

Date of Birth _____/_____/_____Home Phone (_____) - _____

Employment Information

Employment Status (If minor, parent's): _____Employed _____Student _____Other

Employer _____Occupation _____

EMERGENCY CONTACTS

Name _____Phone (_____) - Relation _____

Name _____Phone (_____) - Relation _____

PLEASE READ AND INITIAL

I authorize Hartwell Family Practice, PC to release any information needed by my insurance company to process my insurance claims. I also authorize payment to Hartwell Family Practice, PC for any payments otherwise payable to me. Over-payments will be refunded to the appropriate party. _____(initial)

I am aware that a finance charge of $3.00 will be added to my account on all balances more than 30 days old _____(initial)

I have received a copy of the Hartwell Family Practice Notice of Privacy Practices _____(initial)

_____

Patient's signature (If minor, guardian's signature)