Academy Primary Care

New Patient Information and Consent

What is the reason for your visit today?

Patient Information

Name (First, Middle, Last)	Date of Birth	Age	SSN	Birth Gender
				☐ M ☐ F

Mailing Address	Apt #	City, State, ZIP

Email Address	Primary Phone ☐ Home ☐ Cell	Okay to leave message? ☐ Y ☐ N

Marital Status	Appointment Reminder Preference
☐ Single ☐ Married	☐ Call ☐ Text ☐ Email

Preferred Language	Race
	☐ Black or African American ☐ Native Hawaiian or other Pecific Islander ☐ American Indian/Alaska Native ☐ White ☐ Asian ☐ Other ☐ Prefer not to answer
Ethinicity	
☐ Hispanic or Latino ☐ Not Hispanic or Latino	

Emergency Contact

Contact Name	Phone Number	Relationship to Patient

Medical Insurance

Primary Insurance Company	Policy Number	Group Number

Insured Name	Insured Date of Birth	Patient Relationship to Insured
		☐ Self ☐ Spouse ☐ Dependent

Insurance Company Address	Phone

Patient Consent for Treatment

1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Academy Primary Care and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Academy Primary Care.

2. I agree to be contacted via email or SMS with information related to my visit, like; a patient portal invitation, post-visit satisfaction survey, appointment or checkup reminders, health tips, or new services that relate to me or my family.

3. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the Academy Primary Care Notice of Privacy Practices.

4. I authorize payment of medical benefits to Academy Primary Care physicians or their designee for services rendered.

5. I give permission to obtain all medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

I have received a copy of the Notice of Privacy Practices. ☐ **Yes** ☐ **No**

I have received a copy of Financial Policies and Procedures. ☐ **Yes** ☐ **No**

I have received a copy of Patient Rights and Responsibilities. ☐ **Yes** ☐ **No**

X _____ _____

Patient or Authorized Person's Signature *Date*