FAMILY HEALTH ASSOCIATES
Patient Information

Date _____

Patient _____ **Birthdate**: _____
Last Name First Name Middle Initial

Street Address _____ **City** _____ **State** _____ **Zip Code** _____

Mailing Address _____ **City** _____ **State** _____ **Zip Code** _____

Social Security # _____ **Email address**: _____

Gender Identity: __Male __ Female __Transgender Male __Transgender Female
__Neither Male or Female __Other __Declined

Sexual Orientation: __Straight __Gay __Lesbian __Bisexual __Other __Unknown __Declined

Marital Status: __Single __Married __Divorced __Widowed

Race: __Asian __Black/African American __Caucasian/White __American Indian/Alaskan Native
__Native Hawaiian/Pacific Islander __Unknown

Ethnicity: __ Hispanic/Latino __Not Hispanic or Latino **Preferred Language:** _____

Home Phone # _____ **Cell Phone #** _____ **Work Phone #** _____

Which is your preferred phone? Home / Cell / Work **Employed by** _____

In case of emergency, who should be notified _____ **Relationship** _____ **Phone #** _____

Second contact person _____ **Relationship** _____ **Phone #** _____

Who is responsible for this account? _____ Relationship to patient _____

Mailing Address _____ City _____ State _____ Zip Code _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Social Security # _____ Birthdate _____ ❑ Male ❑ Female Employed by _____

Name of primary Insurance Company _____ Employer: _____

Subscriber Name _____ SS # _____ DOB _____

Name of secondary Insurance Company _____ Subscriber Name: _____DOB_____

Name of Preferred Pharmacy _____ City: _____

Do you have Medicare? ❑ Yes ❑ No Medicare # _____ Medicare Part D Provider _____

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Authorization for Treatment

By signing below I am allowing Family Health Associates (FHA) to provide health care related treatment and consultation to the previously-named patient and that I may refuse treatment or services at any time. I understand FHA does not guarantee any outcome for any services or treatment either stated or implied.

Signed _____ Date _____ Relationship to patient _____

Assignment, Release and Authorize

I, assign directly to Family Health Associates, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signed _____ Date _____ Relationship to patient _____

HIPAA (Health Insurance Portability and Accountability Act)

I understand that I have the right to receive and review a written description of how Family Health Associates will handle my health information. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Family Health Associates and my right regarding my health information.
I understand that the **Notice of Privacy Practices** may be revised from time to time, and that I am entitled to receive a copy of any revised **Notice of Privacy Practices**. I also understand that a copy or summary of the most current version of Family Health Associates' **Notice of Privacy Practices** in effect will be posted in the waiting/reception area.

Signed _____ Date _____ Relationship to patient _____

Permissions (these permissions will stay in effect until changed by patient or parent/guardian)

I give my permission for FHA to speak with and/or leave messages with regarding treatment, billing and/or appointment status (name of each person and relationship to patient)

_____

_____

Signed _____ Date _____ Relationship to patient _____