PATIENT ENROLLMENT FORM

NP_____ Ent_____

Thank you for taking the time to be as complete and accurate as possible. Date_____

PATIENT INFORMATION

Patient Full Name_____ **Date of Birth**_____ /_____ /_____

Preferred Name_____ **Maiden Name**_____ **Sex M / F**

Address_____ **Apt #**_____ **City**_____ **State**_____ **Zip**_____

Home Phone (_____**)**_____ **Mobile Phone (**_____**)**_____ **Work Phone (**_____**)**_____

Social Security_____-_____-_____ **Marital Status S**_____ **M**_____ **D**_____ **W**_____

Race _____ **Ethnicity: Hispanic / Latino / Other** **Primary Language**_____

Preferred Pharmacy _____ **Pharmacy City**_____

Spouse's Name_____ **Spouse's DOB**_____ /_____ /_____

Nearest Relative _____ **Phone Number (**_____**)**_____ **Relationship**_____

Emergency Contact_____ **Phone Number (**_____**)**_____ **Relationship**_____

INSURANCE INFORMATION

PRIMARY INSURANCE:

Policy Holder Name_____ **Date of Birth**_____/_____/_____ **Relationship to Patient**_____

Address (if diff from above)_____ **City**_____ **State**_____ **Zip**_____

Ins Company Name_____ **Policy/ID #**_____**Group #**_____ **Copay $**_____

Ins. Address_____ **City**_____ **State**_____ **Zip**_____

SECONDARY INSURANCE:

Policy Holder Name_____ **Date of Birth**_____/_____/_____ **Relationship to Patient**_____

Address (if diff from above)_____ **City**_____ **State**_____ **Zip**_____

Ins Company Name_____ **Policy/ID #**_____ **Group #**_____ **Copay $**_____

Ins. Address_____ **City**_____ **State**_____ **Zip**_____

NOTIFICATION PREFERENCES

Preferred method of contact for appointment reminders: (select one) **Email** _____ **Phone Call** _____ **Text** _____

Email Address_____ **Cell Phone (**_____**)** _____

I understand that Grandview Family Medicine cannot guarantee the security of the email address and phone number once it has been given. I understand that my medical information is confidential and protected by HIPAA. I waive this privilege relating to all information sent via electronic communication. I release Grandview Family Medicine from any responsibility should my personal health information be received, intercepted, viewed, forwarded, read, or shared in any way as a result of Grandview Family Medicine sending an electronic communication to me. I understand that it is my responsibility to inform Grandview Family Medicine if any of the above information changes or becomes inactive.

Patient Signature_____ **Date**_____

PLEASE READ AND SIGN THE BACK PAGE OF THIS FORM!

GRANDVIEW
FAMILY MEDICINE
My Health, My Family, My Clinic-

MEDICAL INFORMATION RELEASE

I acknowledge that I have been provided a copy of the NOTICE OF PRIVACY PRACTICE (HIPAA) of Grandview Family Medicine and that Grandview Family Medicine may release all or portions of my medical record to me, and to people or companies responsible to pay the charges for my care, such as my insurance or health benefits companies, or worker's compensation carriers. I further acknowledge that Grandview Family Medicine may disclose my patient information to referring or treating health care providers, and for payment and health care operations. I hereby authorize Grandview Family Medicine to obtain my medical information from other health care entities and providers, including but not limited to, copies of lab results, diagnostic test reports, films/images, and other clinic information deemed necessary by Grandview Family Medicine physicians or representatives. I understand that I may inspect my protected health information, request more information, and revoke this authorization, as permitted by the federal privacy regulations and in accordance with Grandview Family Medicine's privacy policy.

Patient/Responsible Party Signature: _____ Date: _____

CONSENT FOR SERVICES

I hereby give consent to the Facility, its contractors, physicians, and employees to provide health care services to the Patient and to administer physician orders for the benefit of the Patient for this visit and any subsequent visits. I understand this consent may be revoked in writing at any time. I understand that there is a risk of substantial and serious harm involved in such health care services, and I accept such risk in the hope of obtaining beneficial results from such services. No promises of any particular outcome or successful result have been made. I understand and accept that there is some uncertainty involved in the health care services for which this consent is given. I understand that physicians are separately responsible to explain what they do and, in some cases, to obtain separate consent for some of the services they perform.

Patient/Responsible Party Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY

I hereby authorize any insurance payments due to me to be paid directly to Grandview Family Medicine. I understand and agree that I am financially responsible for all co-pays, deductible amounts, co-insurance, non-covered services or services deemed as "non-medically necessary" by my third party insurance carrier. **I understand that any additional testing may be sent to an outside laboratory for processing and may not be covered. I understand that it is the responsibility of the patient/responsible party to verify insurance coverage for any additional testing done and that I will receive a separate bill for those services.** I understand that I am responsible for satisfying any conditions necessary for insurance or health benefits. **I agree to pre-pay $60 toward services provided if insurance plan has a deductible (does not apply to preventative exams).** If I am unable to pay a co-pay by 7:00pm on the date of service, a $10 billing fee will be applied. I understand and agree that any amounts not paid within 30 days of the date of the Facility's bill or statement for payment shall accrue interest at the rate of 1.5% per month (18% per year) on the unpaid balance. In the event that any unpaid balance is placed with a collection agency or attorney for collection, I agree to pay costs and reasonable attorney's fees in connection with the collection process. A service charge may be collected in connection with any check or other instrument tendered by the Patient but returned unpaid to the Facility. It is the responsibility of the Patient to confirm that the doctor you are seeing is on your insurance provider list. If the Patient has no medical insurance the Facility will provide a discount on the amount due for the office visit. The total amount is due on the date of service.

Patient/Responsible Party Signature: _____ Date: _____

MEDICARE/MEDICAID/TRICARE PATIENT'S CERTIFICATION

I certify that the information given by me in applying for payment under Titles XVII and XIX of the Social Security Act or in connection with any other government program is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, other intermediaries or carriers, or the State any information needed to process a claim for this or any related service. I request that payment of authorized charges be made in my behalf directly to Grandview Family Medicine for its charges and for any charges of physicians or other providers for whom the Facility is authorized to bill in connection with its service.

Patient/Responsible Party Signature: _____ Date: _____

Employee Signature: _____ Date: _____