Hometown Family Medicine, Inc.

PATIENT INFORMATION (Please Print)

Name _____ Social Security #_____-_____-_____
Last First M.I.

Address _____
Street

_____ _____ E-mail _____
City State Zip *Would you like to receive emails/text from us? ☐yes ☐no

Patient's Date of Birth _____/_____/_____ Age_____ Marital Status (circle one) S M D W

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Patient's Employer _____ Occupation _____

Work Phone (_____) _____-_____

If Married, Spouse's Name _____ Employer _____

Who were you referred by?_____

INSURANCE **Please provide insurance card to receptionist**

Insured's Name _____Relation to Patient_____ Insured's DOB _____

Insured's Employer (if other than patient) _____Employer Phone # (_____) _____-_____

Insurance Company _____ Insured's Social Security No. _____

Contract/Policy # _____ Group # _____ Effective Date _____

Insured's Address (if different from patient) _____

- **Consent for treatment** – I consent to necessary treatment, including medications, performance of diagnostic testing, labs, or other studies that may be used by the nurse practitioner and her staff.
- **Authorization for release of information** – I authorize the release of any and all my treatment and service information to third parties to facilitate billing, collection or referrals for services to other providers.
- **Non-covered routine services & collection policy** – As your healthcare provider, I want to provide you with the best care possible. There may be certain routine services that I feel are necessary for the maintenance of your good health that are not covered by your health insurance contract. I would appreciate your cooperation in paying for these services in a timely manner. This may include, but not limited to, lab procedures, pathology services, injections, and/or diagnostic tests. These may not be covered by your contract.
- The nurse practitioners have agreed that the amount allowed by your insurance becomes the total charge for any service. However, patients are responsible for any amount applied to the deductible and the co-insurance amount. Co-payment is due at time of service. Any remaining balance is due within 30 days of date of service.
- By signing below, you accept the responsibility for any costs not covered by your insurance. You also accept responsibility for any collection costs including, but not limited to, reasonable attorney's fees and court costs.
- **Private pay** – I understand that an initial payment will be due at the time of service. I also understand that I am responsible for any additional charges that may incur from my visit(s).

I have read your policy and agree to be held responsible for the services.

I have been offered a copy of the Privacy Statement adopted by Hometown Family Medicine, Inc. on November 18, 2014.

Signature _____ **Date**_____