# PERSONAL & INSURANCE INFORMATION

NAME: ______________________________________________________________________________

ADDRESS: ____________________________________________________________________________

CITY: ____________________________ STATE: _________ ZIP CODE: _________________

MARITAL STATUS: ______ EMAIL: _______________________________________________________

INSURANCE______________________________ ID#_______________________________________

GUARANTOR ____________________________ GUARANTOR DOB________________________

AUTHORIZATION TO RELEASE INFORMATION:
I / We hereby authorize Wrightstown Family Medicine to release any medical or incidence information that may be necessary for medical benefit or in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.
CONSENT FOR TREATMENT:
I / We hereby authorize Wrightstown Family Medicine to administer diagnostic and medical procedures as may be necessary for proper health care.
OFFICE POLICY ON PAYMENT:
I / We understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid for by my insurance company. I authorize insurance benefits to be paid directly to the provider.

Signature: ___________________________________________________________________

This is to certify that the HIPAA Regulations have been explained to me verbally. In general the HIPAA privacy rule gives the right to request a restriction on uses and disclosures of the protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means. Wrightstown Family Medicine will not use or disclose your protected health information without a specific written authorization from you. You may revoke at any time. We are unable to take back any disclosures we have already made with your permission, and we are required to retain our records of the care that we provided to you.

HIPAA Patient Signature (or Guardian):_______________________________________________

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER:

Home Phone Answering Machine: Yes No Home # ______________________________
Cell Phone: Yes No Cell # ________________________________
Spouse Notification: Yes No Name: ________________________________

Other Notification: (Please be Specific)____________________________________________

Emergency Contact: Name/ Phone #_________________________________________________
Relationship: _____________________________________________________