**WRIGHTSTOWN FAMILY MEDICINE**

PERSONAL & INSURANCE INFORMATION

(Please complete both pages)

**DATE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GENDER: \_\_\_\_\_\_\_\_\_\_\_

(As listed on Ins Card, NO nickname please)

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP CODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY INSURANCE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ID#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUBSCRIBER/Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GENDER\_\_\_\_\_\_\_\_\_\_

Subscriber’s relationship to the patient? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*IF YOU HAVE MEDICARE, WHAT IS YOUR PART-B EFFECTIVE DATE (SHOWN ON YOUR ID CARD): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**SECONDARY INSURANCE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ID#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUBSCRIBER/Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GENDER\_\_\_\_\_\_\_\_

Subscriber’s relationship to the patient? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*IF YOU HAVE MEDICARE, WHAT IS YOUR PART-B EFFECTIVE DATE (SHOWN ON YOUR ID CARD): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**TERTIARY(3rd) INSURANCE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ID#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUBSCRIBER/Policy Holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GENDER\_\_\_\_\_\_\_\_

Subscriber’s relationship to the patient? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\***Your last Annual/Preventative Physical Exam (patients with commercial insurances & Medicare Advantage plans):

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LOCATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\***Your last screening Annual Wellness Visit (patients with either traditional Medicare or Medicare Advantage plans):

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LOCATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If unsure, you may contact your insurance or your prior PCP for the date of your last Physical and/or AWV*

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* **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.
* **PATIENT FINANCIAL RESPONSIBILITY/FEES:** 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. I understand that a $50 Admin/Late Fee will be applied to aging balances. I understand if I cannot keep my scheduled appt time and the office is not notified via Phone Call (not a Portal message) 24 hours business days in advance, a Missed Appt fee of $50 for a 15 min appt or $95 for a 30 min appt will be applied to my account (cancelling a Monday appt would require calling the office the Friday prior to a Monday appt). I understand aging balances will be forwarded to Dignity Collect which will result in discharge from the practice.
* **GUARANTOR (Financial responsibility)**: For ALL minors, their parent/or legal guardian is financially responsible.

**SIGNATURE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA PRIVACY POLICY**

This certifies 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.

* **I give permission for the following person(s) to communicate on my behalf regarding PHI (including Billing issues):**

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient HIPAA Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **I WISH TO BE CONTACTED IN THE FOLLOWING MANNER**:

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Notification: (Please be Specific) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **EMERGENCY CONTACT:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_