PATIENT INFORMATION FORM

Last Name:_____ **First Name:**_____ **MI**:_____

Date of Birth:_____ **Marital Status:** ▢ Married ▢ Single ▢ Widowed ▢ Divorced
Gender: ▢ Male ▢ Female

Home Address:_____

City:_____ **State:**_____ **Zip:**_____ **Email:**_____

Preferred Phone: _____ ▢ Cell ▢ Home ▢ Work

Secondary Phone:_____ ▢ Cell ▢ Home ▢ Work

Local Pharmacy:_____ Cross Streets or Phone #:_____

Emergency Contact Name:_____ **Relationship:**_____

Phone #:_____ Address:_____ City:_____ State:___ Zip:_____

HIPAA: Please list anyone with whom we may discuss your health information:
May we discuss your private medical information with your Emergency Contact? ▢ Yes ▢ No

Please list anyone else you authorize us to discuss your private health information.

Name/Relationship:_____ Phone:_____

May we obtain your medical records from your other healthcare providers, hospitals, or other healthcare facilities that are available to us through interlinked healthcare provider portals? ▢ Yes ▢ No

Guarantor, who is responsible for the bill: ▢ Self ▢ Same as Emergency Contact

▢ Other: Name:_____ Relationship:_____

Phone #:_____ Address:_____ City:_____ State:___ Zip:_____

CONSENT FOR MEDICAL TREATMENT

Patient Name: _____ Date of Birth: _____

As the patient/authorized representative, I am requesting to receive medical evaluation/treatment services.

I understand that:

- I have the right and am encouraged to discuss any medical treatments with my provider.
- I have the right to refuse any procedure or treatment.
- I consent to have photographic images be taken for the purpose of patient identification and documentation of medical conditions. I understand these photographs are protected patient information and will not be shared beyond the purpose of medical care without my written consent.
- Care may include, but is not limited to, medical evaluation, diagnostic laboratory and radiological procedures, and the administration of medications and therapies considered advisable in my diagnosis, treatment, and course of care.
- I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations and I understand that all medical treatments contain inherent risks.

Privacy Practices

The security of your protected health information is the highest priority to us. We have developed Privacy Practices to inform you how we safeguard your information. We provide the notice of these practices to our patients. You may choose to decline review

___I have received a copy of the Privacy Practices

___I do not wish to receive a copy of the Privacy Practices

I understand that I may ask questions to the staff at any time regarding the use and protection of my protected health information.

Patient Signature:_____ Date: _____

MEMBERSHIP FEE

$5,000/year for each member

for the first 100 members

Fee subject to change after our first 100 members

This fee will include the following:

1) We will perform a very thorough and extensive health assessment and physical examination with a focus on Preventive and Comprehensive Care.

2) We will make all of the necessary arrangements for any Referrals and/or Further Testing that might be required.

3) We will obtain one set of labs to be run in our own lab to include the following:
   a) CBC (Complete Blood Cell Count)
   b) CMP (Comprehensive Metabolic Panel)
   c) U/A (Urine analysis)
   d) Lipid Panel
   e) HgbA1c (Glycolated Hemoglobin)

4) We will send out the following labs to Quest
   a) TSH (Thyroid Test)
   b) PSA (Prostatic Specific Antigen) - men

5) EKG

6) CXR (Chest X-Ray)

7) Unlimited Telemedicine Calls as needed

8) Availability for same day appointments

9) Direct Access 24/7 from anywhere in the world via phone, text or email for any Emergency

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand that the practice may amend such terms from time to time as necessary.

Patient Signature:_____Date:_____

FINANCIAL POLICIES & PRACTICES CONSENT

SELF PAY - NO INSURANCE

No billing to commercial insurance:

- Our Primary Care division does not bill commercial insurance plans. All services provided are considered self-pay. The patient (or responsible party) is fully responsible for payment of all charges incurred for services rendered.

Courtesy claim submission for possible reimbursement

- As a courtesy, upon request, our office will submit a claim to your personal insurance carrier for possible reimbursement directly to you. Submission of a claim does not guarantee payment. Any reimbursement issued by your insurance company will be sent to you, not to our office.

Payment Process

- Payment is not required at the time of service. After services are completed, an invoice will be sent to you based on your preferred delivery method (email or mail).
- You can pay your balance via cash, check, zelle, and/or credit card. A transaction fee for any card transaction will apply.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand that the practice may amend such terms from time to time as necessary.

Patient Signature:_____Date:_____

FINANCIAL POLICIES & PRACTICES CONSENT

TRADITIONAL MEDICARE

The Center for Primary Care is in-network with Traditional Medicare. After you have paid the Membership Fee, we will submit claims directly to Medicare and we will accept assignments from Medicare directly.

As a Medicare participating provider, we are required to follow all Medicare rules and regulations, including those related to cost-sharing. Medicare requires providers to collect any applicable patient responsibility amounts. Depending on your plan, this may include a deductible, copayment, and/or coinsurance.

When laboratory studies, diagnostic tests, or referrals to other providers are needed that are not performed within our facility, we will provide your Medicare information to those entities so they may file on your behalf. Please note that any associated fees/copays/coinsurance/deductibles that those entities may charge will be your responsibility. The Center for Primary Care is not privy to the fees and prices any other medical service provider charges.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand that the practice may amend such terms from time to time as necessary.

Patient Signature:_____Date:_____

Consent of Release/Request of Medical Records

Patient Name: _____ DOB: _____
Street Address: _____
City: _____ State: _____ ZIP: _____

Authorization Given to:
Name of Facility: _____
Address: _____
City: _____
State: _____ ZIP: _____
Phone:_____ Fax: _____

To release protected health records to:
Name of Facility: _____
Address: _____
City: _____
State: _____ ZIP:_____
Phone:_____Fax:_____

Information to be released:
___ Full Medical Record as held by this office
___ Medical Records for the period _____ through _____
___ Specific information, as requested below:
_____

Purpose for need of disclosure:
___ Further Medical Care
___ Other (specify) _____

*** YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

I understand that The Center for Primary Care will not be able to release my medical records to someone else without a signed authorization. By signing this authorization, I expressly and voluntarily consent to the disclosure to the disclosure of information checked above to the person/doctor/agency named above. I understand if the person and/or organization listed above is not mandated by the federal privacy standards, the health information disclosed as a result of this authorization may be re-disclosed without obtaining my authorization. I understand that I may be charged a fee for copying these medical records.

Signature: _____ Date: _____