Patient Profile

Date: ______________________

Physician Name ______________________

PATIENT INFORMATION

Name: ______________________

Address: ______________________

____

City,State: ______________________

Phone: ______________ [ ] Home [ ] Work [ ] Other

Phone: ______________ [ ]Home [ ]Work [ ]Other

Sex: M( ) F( )

Date of Birth: ______________________

Social Security #: ______________________

Marital Status: [ ] Married [ ] Single [ ] Divorced

Referring Physician: ______________________

Primary Physician: ______________________

PATIENT EMPLOYMENT

[ ] Employed [ ] Retired [ ] Unemployed [ ]Student

Phone: ______________________

Employer: ______________________

EMERGENCY CONTACT

Name ______________________

Relationship ______________________

Phone Number ______________________

Legally Responsible (Guarantor)

[ ] Same as Patient

Name: ______________________

Address: ______________________

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City,State: ______________________

EMPLOYMENT

Employer: ______________________

Phone: ______________________

Phone: ______________________

Social Security #: ______________________

Date of Birth: ______________________

PRIMARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party: ______________________

Insured Phone: ______________________

Company: ______________________

Relationship to Primary Insured/Guarantor: ______________________

Social Security #: ______________________

Insured ID: ______________________

Policy Group: ______________________

Date of Birth: ______________________

SECONDARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party: ______________________

Insured Phone: ______________________

Company: ______________________

Relationship to Primary Insured/Guarantor: ______________________

Social Security #: ______________________

Insured ID: ______________________

Policy Group: ______________________

Date of Birth: ______________________

Financial Agreement & Release of Information

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Palouse Medical, P.S. for any services furnished to me by Palouse Medical, P.S. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Service and its agents any information needed to determine these benefits or the benefits payable for related services.

I authorize the release of my personal Health Care Information that might be required for processing my insurance claims by insurance companies through which I am covered, or any subsequent insurance companies from which I obtain coverage.

Office Policy Agreement

I understand that my services will be billed to my insurance company(s) provided I have given proof of my insurance coverage at the time services are rendered. ***If I do not have proof of insurance coverage at the time services are rendered, I understand that payment is due at the time of service.*** *I will promptly pay all amounts that have been determined my responsibility by my insurance carrier within 30 days of notification.*

If I am ***over*** *the age of 18, I am ultimately responsible for any patient balance for services I have received. If I am* ***under*** *the age of 18, my parent or legal guardian is responsible for my patient balance* ***until*** *my 18th birthday.*

Patient Signature____

Signature of Parent/Legal Guardian____

Date __________________________

Notice of Privacy Practices – Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Privacy Officer.

Our ***Notice of Privacy Practices*** *describes in more detail how your health information may be used and disclosed, and how you can access your information.*

__________ **I acknowledge receipt of the Notice of Privacy Practices.**
Initials

Form Filled Out Entirely______________
Employee Initials

This form will be retained in your medical record.
Last Update: 10/12/2007