

Patient Profile

Date: _____

Physician Name: _____

PATIENT INFORMATION

Name: _____

Address: _____

City, ST, _____ Zip _____

Primary Phone (_____) _____ [] Home [] Work [] Other

Secondary Phone (_____) _____ [] Home [] Work [] Other

Date of Birth: _____ Sex: [] M [] F

Social Security #: _____

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

E-mail _____

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

Employer: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone Number: _____

If applicable please fill out the three items below:

Referring Physician _____

Primary Physician: _____

Name of Assisted Living Facility _____

LEGALLY RESPONSIBLE (GUARANTOR) INFORMATION

[] Same as Patient

Name: _____

Address: _____

City, ST, _____ Zip: _____

Employer: _____

Phone: (_____) _____

Phone: (_____) _____

Social Security #: _____

Date of Birth: _____

PRIMARY INSURANCE

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

Insured Party: _____

Insured Phone: _____

Company: _____

Insured ID: _____

Policy Group: _____

Relationship to Primary: _____
Insured/Guarantor

Social Security #: _____

Date of Birth: _____

SECONDARY INSURANCE

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

Insured Party: _____

Insured Phone: _____

Company: _____

Insured ID: _____

Policy Group: _____

Relationship to Primary: _____
Insured/Guarantor

Social Security #: _____

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