Columbia View Family Health Center

PATIENT INFORMATION

PATIENT'S LAST NAME	FIRST NAME MI	DOB	RACE	ETHNICITY	LANGUAGE

STREET ADDRESS APT#	CITY	STATE	ZIP	SOCIAL SECURITY #

MAILING ADDRESS (IF DIFFERENT)	Preferred Form of Contact: Letter Phone Email	SEX (CIRCLE ONE) M F

HOME PHONE #	WORK PHONE EXT.	CELL PHONE	MARITAL STATUS

PATIENT EMPLOYER	EMPLOYER'S ADDRESS CITY STATE ZIP

SPOUSE'S NAME	SPOUSE'S WORK # EXT.

GUARANTOR INFORMATION - Person responsible for payment, if other than self

GUARANTOR'S LAST NAME	FIRST NAME	RELATIONSHIP TO PATIENT	GUARANTOR DOB	SOCIAL SECURITY #

GUARANTOR'S ADDRESS	HOME PHONE #

GUARANTOR'S EMPLOYER	WORK PHONE# EXT.

INSURANCE INFORMATION

PRIMARY INSURANCE	EFF.DATE	ID#	GROUP #

ADDRESS CITY STATE ZIP	PHONE #

NAME OF INSURED	INSURED'S EMPLOYER	PATIENT RELATIONSHIP TO INSURED	SOCIAL SECURITY #	DOB

SECONDARY INSURANCE	EFF.DATE	ID#	GROUP #

ADDRESS CITY STATE ZIP	PHONE #

NAME OF INSURED	INSURED'S EMPLOYER	PATIENT RELATIONSHIP TO INSURED	SOCIAL SECURITY #	DOB

COMMUNICATION AUTHORIZATION

IN CASE OF EMERGENCY, OR IF WE ARE UNABLE TO REACH YOU, WHO MAY WE CONTACT?

Name _____ **Relationship** _____ **Phone #**_____

PERMISSION TO RELEASE INFORMATION- Please Read

I hereby authorize Columbia View Family Health Center to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry our my treatment, payment and other health care operations. My protected health and financial information may be released to the following individual(s):

Name _____Relationship to patient _____ Phone # _____

Name_____ Relationship to patient _____ Phone # _____

ASSIGNMENT OF BENEFITS:

I hereby assign to Columbia View Family Health Center, PC any insurance, or other third party benefits available for health care services provided to me. I also understand that if benefits are assigned, or if by contractual arrangement, payment to the practice will be made by my insurance, that I am responsible for any co-payments and deductibles and that these amounts are due at the time services are rendered. I understand that the above practice has the right to refuse or accept assignment of such benefits (except when prohibited by contract). I also understand that in the event that services rendered are not covered under my insurance I will accept financial responsibility for all services provided to me and I have 3 months to pay in full. I hereby acknowledge that I received and reviewed Columbia View Family Health Center Payment Policy. If I am delinquent on my account I understand I will be liable for any interest or attorney costs that may be added as the result of being turned over to a collection agency. **ACKNOWLEDGEMENT AND AUTHORITY:** I consent to treatment by all the doctors practicing medicine at Columbia View Family Health Center, as necessary or desirable to the care of the patient first named above.

Signature of Patient/ Legal Guardian _____ **Date** _____

Signature of Guarantor (if other than patient _____**Date** _____