EraCare Physicians New Patient Packet

Effective 01/01/2016

NEW PATIENT INFORMATION

Today's Date: **Account number:** **MD #:**

DEAR PATIENT: We have made every attempt to reduce the amount of paperwork that you need to fill out and also make the process more efficient. Your cooperation and correct completion of the information below will assist us in obtaining the information correctly the <u>first time</u>. Please provide a copy of your primary and secondary (if applicable) insurance card to the front desk with your paperwork. ***THANK YOU***

Is your condition a result of a work injury?______________________ Or related to an auto accident?________________

PATIENT INFORMATION:

SS #:________________________ DL #:________________________

Last name: ____________________________ **First name:**______________________________ **MI:**________________

Address: ____ **City:** __________________ **State:**________ **Zip:**_________

Phone #: ____________________ **Cell #:** _____________________ **Email:**______________________ **DOB:**_________

AGE: _________ **M:** __________ **F:** ___________ **Marital Status:**_______________

Your Employer: ____ **Occupation:**________________________________

Work Address: ____ **City:**____________________

State/ Zip: ________________________________ **Work #:** _____________________ **Work Email:** _________________

Emergency Contact: _________________________ **Phone #:** ____________________ **Cell #:** _____________________

Patient relationship to primary cardholder: Self:________________ **Spouse:** ____________ **Other:**________________

If you are not the primary cardholder please complete next box.

PRIMARY AND SECONDARY CARDHOLDER INFORMATION: Please complete this section if the patient <u>is not</u> the primary cardholder for their primary and secondary insurance. This information is REQUIRED BY YOUR insurance company for identification of policyholder and correct billing.

Cardholder's name:__________________________________ **Cardholder's Occupation:**___________________________

Cardholder's Employer: ______________________________ **Cardholder's work #:**_______________________________

Cardholder's SS #: __________________________________ **Cardholder's DOB:** _______________________________

PATIENT REFERRAL INFORMATION: Your insurance company and EraCare Physicians require this information if applicable.

Referring MD: (full name)____ **Phone #:**__________________________

For office use:

- ☐ Copy of primary card attached
- ☐ Copy of secondary card attached
- ☐ Waiver signed and attached
- ☐ Referral obtained and attached
- ☐ Demographic entered and attached
- ☐ Employee Initials ____________

Permissions, HIPAA, Consents & Disclosures

Minor Patients: EraCare Physicians does not get involved with divorce or separation issues. For all services rendered to minor patients, EraCare Physicians will look to the adult accompanying the minor patient and/or the parent or guardian with custody for payment.

Assignment of Benefits: I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to EraCare Physicians LLC for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any.

Consent for Treatment: I understand my right to participate in my treatment process. I am mentally competent and do hereby consent to necessary examination, procedures and/or treatments prescribed by my physician, his/her assistants or designee as is necessary in his/her judgment.

Authorization to Release Information: I hereby authorize EraCare Physicians to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

HIPPA: I acknowledge that EraCare Physicians has provided me with a copy of the HIPPA policy and posted the policy throughout the clinic. I acknowledge that I can request a copy of EraCare Physician's Notice of Privacy Policy at any time.

I have read and understand the **PERMISSIONS, CONSENTS AND DISCLOSURES** of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time. I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

Printed Patient Name:____ Relationship to Patient:_______________

Signature:____ Date:_______________________________

Patient Signature & Authorization

Effective policy date 01/01/2016

Please initial each section and sign at the bottom.

_____I have received a copy read and understand this **Patient Financial Responsibilities Policy** and I agree to be bound by its terms and conditions. I also understand and agree that EraCare Physicians may amend such terms from time to time.

_____HIPPA: I acknowledge that EraCare Physicians have provided me with a copy of the **HIPPA** policy and posted the policy throughout the clinic. I acknowledge that I can request a copy of EraCare's Notice of Privacy Policy at any time.

_____I have read and understand the **Clinic Policy** of the practice and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____I have read and understand the **Patient Rights and Responsibilities** and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____I have read and understand **IN A NUTSHELL** and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____**PERMISSIONS TO YOUR INFORMATION**: Please list the name of any individuals, and the last 4 digits of the individuals' Social Security number or password, with which you agree, we may release or discuss your confidential health information.

____

Name SS # or Password Relationship

____

Name SS # or Password Relationship

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Name SS # or Password Relationship

My signature acknowledges receipt and understanding of 1. Patient Financial Responsibilities Policy, 2. Practice Clinic Policy, 3. HIPPA, Notice of Privacy Practice 4. Patient Rights & Responsibilities 5. In A Nutshell, 6. Permissions, Consents and Disclosures & 7. Completion of Permissions to your Information each with the effective date 01/01/2011. I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

Printed Patient Name:____ **Relationship to Patient:**_______________

Signature:____ **Date:**_______________________________