HORN LAKE FAMILY PRACTICE

Patient's Full Legal Name:_____

Street Address:_____ Apt. #:_____

City:_____ State:_____ Zip: _____

Home Telephone: (_____)_____ Date of Birth _____ / _____ / _____ Sex: ☐ Male ☐ Female

Social Security #: _____ - _____ - _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Employer Name: _____ Work Phone: _____

Employer Address:_____ City:_____ State:_____ Zip:_____

Occupation:_____ Spouse's Full Legal Name: _____

Cell Phone: (_____)_____

Can we leave messages regarding your care (i.e. lab results, x-ray results) at this number? ☐ Yes ☐ No

PARENT INFORMATION: If the patient is not responsible for payment

Name of Person Who Carries the Insurance:_____ Relation to Patient:_____

Address (If different from patient): _____

City:_____ State:_____ Zip: _____

Home Telephone: (_____)_____ Work Telephone: (_____) _____

Social Security #:_____ - _____ - _____ Date of Birth:_____ / _____ / _____ Sex: ☐ Male ☐ Female

PRIMARY INSURANCE INFORMATION

Insurance Name:_____ Group Number: _____

Address:_____Policy Number: _____

City State Zip:_____Policyholder Name (who carries the insurance):_____

Telephone: (_____)_____ Copayment:_____

SECONDARY NSURANCE INFORMATION

Insurance Name:_____ Group Number: _____

Address:_____Policy Number: _____

City State Zip:_____Policyholder Name (who carries the insurance):_____

Telephone: (_____)_____ Copayment:_____

EMERGENCY CONTACT: someone not living in your household

Name:_____ Relationship to Patient: _____

Telephone: (_____)_____

ADVANCED BENEFICIARY NOTICE

Insurance payers will pay for services that they determine to be reasonable and necessary. If it is determined that a particular service in a particular situation is not reasonable and necessary, the payment will be denied, even though the procedure may sometimes be covered under different circumstances.

Patient Agreement

I have been notified by this office that, in case, my insurance denies payment for office visit, and/or any labs, x-rays or procedures, I agree to be personally and fully responsible for payment. All delinquent accounts are turned over to collection agency, patient will be responsible for collection and/or attorney fees.

Signature of patient or responsible party_____ Date:_____

CONSENT AND DISCLOSURES: I voluntarily consent to treatment for myself and/or my dependents.
RELEASE OF INFORMATION: I authorize Horn Lake Family Practice to release (verbally or in writing) confidential medical information to any person or entity which may be liable to me or my Practitioner(s) for charges for this treatment, and for quality management, utilization review, transfer, and follow-up purposes. I understand that a copy of this agreement may be used with the same effectiveness as an original.

Signature of Patient/
Responsible Party:_____ Date:_____ / _____ / _____