Mount Vernon Internal Medicine

PATIENT INFORMATION

DATE: _____

LAST NAME: _____ FIRST NAME: _____ MI: _____
PREFERRED NAME: _____
ADDRESS: _____
CITY: _____STATE:_____ ZIP: _____
HOME#:_____ CELL#:_____
WORK#:_____
EMAIL: _____
BEST WAY TO CONTACT: Home#____ Cell#_____ Work#____ Text____ Email_____
EMERGENCY CONTACT/RELATIONSHIP_____ _____
PHONE#:_____
EMPLOYER/SCHOOL_____
OCCUPATION/GRADE: _____
PATIENT SSN: _____ DATE OF BIRTH: ___/____/_____ AGE: _____
GENDER (CIRCLE): M F (IF A MINOR) PARENT'S NAME: _____
SPOUSE'S NAME (Optional):_____
ARE YOU: __ MARRIED__ SINGLE__DIVORCED__WIDOWED__SEPARATED

MEDICAL INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE: _____
SUBSCRIBER SSN/ID#_____
SUBSCRIBER NAME: _____
SUBSCRIBER BIRTH DATE: ___/___/_____

SECONDARY MEDICAL INSURANCE? YES NO
SECONDARY MEDICAL INSURANCE: _____
SUBSCRIBER SSN/ID#_____
SUBSCRIBER NAME: _____
SUBSCRIBER BIRTH DATE: ___/___/_____

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FINANCIAL INFORMATION

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. All copays, deductibles and coinsurances are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge of $25 on all returned checks. Payment from my medical insurance is to be paid directly to Mount Vernon Internal Medicine and I understand that (name of medical insurance) _____will be billed as my primary insurance. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made once the claim is processed.

Signature of Patient or Parent/Guardian_____

Date_____

PATIENT NAME: _____

PRIVACY PRACTICES

I have received, read, and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions.

Signature of Patient or Parent/Guardian_____

Date_____

PATIENT NAME: _____

Mount Vernon Internal Medicine

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW

Patient Name:_____
Please Print Name

Patient's Date of Birth:_____

A. Person(s) or Organization(s) authorized to receive the information:
E.G., Spouse's Name and Phone Number, Family member's Name and Phone Number, Employer

B. Specific description of the information that may be used or disclosed (including dates):
E.G., Full Chart, Specific Date of Service

C. Specific description of how the information will be used:
E.G., Background check, School inquiries

D. I hereby authorize this practice to leave a detailed voicemail message regarding my healthcare issues or test results:

HOME # _____, CELL # _____, and/ or

WORK # _____

1) I understand that this authorization **will expire one year from today's date.**
2) I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Mount Vernon Internal Medicine in writing.
3) I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4) I may inspect or copy any information used or disclosed under this agreement.
5) I understand that, if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.

_____ _____
Patient's Signature or Patient's Representative Date

_____ _____
Printed Name of Patient or Patient's Representative Relationship to Patient