Medical Associates
PRIMARY CARE | A MULTISPECIALTY GROUP
"THE CARE YOU CAN TRUST"

Please complete this form in its entirety and sign. Thank you.

Name: _____ DOB: _____
Last First M.I. MM/DD/YYYY

Social Security#: _____ Gender: ☐ Male ☐ Female

Address: _____

Town/City: _____ State: _____ Zip Code: _____

Home #: (___) _____ Cell#:(___) _____ Work#: (___) _____

Preferred: ☐Home ☐Cell ☐Work

Email Address: _____

Employer: _____ Occupation/Title: _____

Emergency Contact Name: _____ Emergency #:(___) _____

Relationship to the patient: _____

Preferred Pharmacy: _____ Phone#: (___) _____

Pharmacy Address: _____

I N S U R A N C E I N F O R M A T I O N

Primary Insurance Carrier: _____ Effective Date: _____

Policyholder's Name: _____ Relationship: _____

Policyholder's Date of Birth: _____ Policyholder's Social Security#: _____

Insurance ID/Certificate#: _____ Group #: _____

PCP Selection Required: ☐Yes ☐No If yes please write the PCP name: _____

Secondary Insurance Carrier: _____ Effective Date: _____

Policyholder's Name: _____ Relationship: _____

Policyholder's Date Of Birth: _____ Policyholder's Social Security#: _____

Insurance ID/Certificate#: _____ Group #: _____

Responsible Party Information – ***Please complete if the responsible for payment is not the patient or the policy holder.***

Responsible Party's Name (Last/First) Responsible Party's SSN Relationship to Responsible Party

_____ _____ _____

Responsible party's Address: _____ Phone#: _____

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I hereby authorize Medical Associates to release to my insurance company or its representative any information, including diagnosis and records, of any treatment or examination rendered to me during the period of medical care rendered by the above.

I authorize and request that my insurance company PAY DIRECTLY to Medical Associates, the amount due from my insurance company for such treatments rendered.

I also hereby confirm that all information noted above, and all insurance cards presented at this time is valid information. If my insurance carrier changes, I will present said valid information immediately. I will be responsible for all said balances in cases when I have not presented valid insurance information.

X_____ _____

Patient/ Parent/ Legal Guardian Authorized Signature Print Name Date

CONSENT FORM

I understand that Medical Associates may need to use and disclose information about my health or medical problems for the purpose of arranging, conducting, or referring my treatment; for obtaining payment for services; and for operating the practice. I consent to the use of my information for the purposes of treatment, payment, and healthcare operations.

I understand that my consent is not needed if the law requires Medical Associates to report some aspect of my protected health information to a government agency, (for example, suspected abuse, communicable diseases and potential for serious bodily harm to myself or others).

I understand that I have the right to review Medical Associates privacy notice, to request restrictions on the use of my information, and revoke my consent later.

I understand that if I withhold consent for the use of my information for the purposes of treatment, payment or operations, Medical Associates may refuse to undertake my care.

_____

Patient/ Parent/ Legal Guardian Authorized Signature

_____ _____

Print Name Date

Contracted Insurance Carrier Fact:

Your insurance carrier has a time limit for submitting claims on your behalf. Our contractual agreement with your insurance requires that we receive accurate insurance information from you, to ensure that your claims(s) is submitted and processed in a timely manner.

Charges for claims denied due to expired/late claim submission, when we are in receipt of incorrect insurance, will be your responsibility.

Referral/PCP: If your insurance company requires you to choose a primary care physician (PCP) it is your responsibility to notify the insurance company that you have chosen your new physician. If you need an insurance referral to see a specialist, you must notify our office before the specialist's visit. If you have an outside PCP, you must obtain a referral for today's visit.

Please sign acknowledging your understanding of the above statement and the above information that you have provided is true to the best of your knowledge.

_____

Patient/ Parent/ Legal Guardian Authorized Signature

_____ _____

Print Name Date