Bay Medical Family Practice, P.C.

PATIENT INFORMATION DATE: _____

PATIENT NAME _____ SS# _____DOB ___/___/____

ADDRESS _____ CITY/STATE/ZIP _____

MARITAL STATUS _____ SEX _____ EMAIL _____

HOME PHONE # _____ WORK PHONE # _____

PATIENT'S EMPLOYER _____ CELL PHONE # _____

PHARMACY NAME _____ CITY _____ PHONE _____

RACE (OPTIONAL): ___WHITE ___BLACK/AFRICAN AMERICAN ___HISPANIC ___NATIVE AMERICAN ___ASIAN ___OTHER

PREFERRED LANGUAGE (OPTIONAL): _____ ENGLISH _____ SPANISH _____ OTHER

ETHNICITY (OPTIONAL): _____ HISPANIC/LATINO _____ NOT HISPANIC/LATINO _____ OTHER

PREFERRED METHOD OF CONTACT: ____ MAIL ____ PHONE

SPOUSE INFORMATION

NAME OF SPOUSE _____ SS# _____ DOB ___/___/_____

SPOUSE'S EMPLOYER _____ WORK PHONE # _____

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY'S NAME (IF DIFFERENT THAN PATIENT)

_____

RELATIONSHIP TO PATIENT _____ SS# _____ DOB ___/___/___

ADDRESS _____ CITY/STATE/ZIP _____

HOME PHONE # _____ WORK PHONE # _____

RESPONSIBLE PARTY'S EMPLOYER _____ CELL PHONE # _____

From time to time, our doctors or staff may need to reach a patient (or the parents or guardian of a patient) directly concerning an appointment, test results, or medical information. It is at the patient's (or parent's or guardian's) discretion when and with whom we share this information. This is due to HIPPA (Health Insurance Portability and Accountability Act of 1996). I consent for this practice to use or disclose information about the patient for the purposes of treatment, payment and health care operations to whomever I have listed below:

____ Myself only ____ My answering machine ____ Those listed below

1. Name _____ Relationship _____ Phone _____
2. Name _____ Relationship _____ Phone _____
3. Name _____ Relationship _____ Phone _____

Patient Signature _____ Date _____

Office use only: Entered by _____ ver 1/2014

Guarantee of Payment

I, the undersigned, hereby agree to pay all amounts and charges incurred by me and/or members of my family for services rendered by the physicians of Bay Medical. I understand that failure to make payment is basis for legal action, and I agree to pay all costs of collection including 30% collection fee on the balance due as well as any court costs incurred. I waive my right of exemption under law of the State of Alabama and any other state. For private pay patients: I agree to pay in full at the time of service.

For patients with insurance: I agree that it is my responsibility to know and understand the provisions and limitations stated in any insurance policy including providers covered by my contract. I accept full responsibility for all charges not covered by any insurance. I understand that insurance is a contract between my insurance company and me. This office is not a party to that contract. The filing of insurance is a courtesy which is extended to me, and all charges are my responsibility.

Assignment of Claims against Third Parties

In consideration of care rendered to me by physicians, I hereby assign to the physicians rendering services all claims that I may have against third parties who may be liable for any of my medical expenses, to the extent necessary to cover by expenses for physicians care and services. Any funds received by me in connection with such claims against third parties, or settlement of such claims shall be paid to the said physicians to cover my expenses. I hereby authorize payment directly to said physicians or their authorized billing agent of any of the above mentioned funds which are otherwise payable to me, but not to exceed the regular reasonable charges for this service.

Medicare Benefits to Physicians

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf for any services furnished to me by physicians. I authorize any holder of medical or other information about me to be released in order to process claims and request payment of my benefits to the physician rendering service.

Medicaid Authorization and Assignment

I authorize any holder of medical information about me to release information needed for this or a related Medicaid claim to the Alabama Medicaid Agency and I authorize the further release of any such information to any other parties who may be liable for any of my medical expenses. I hereby assign to the Alabama Medicaid Agency all claims against third parties who may be liable to any of my medical expenses to the extent that such expenses are paid by Medicaid; I also assign all rights whether or not a portion of any such settlement is designated as being for medical expenses. Any such funds received by me shall be paid to the Alabama Medicaid Agency. I permit a copy of the Authorization and Assignment to be used in place of the original.

Privacy Practices Acknowledgement

I hereby acknowledge that Bay Medical Family Practice has provided me with a notice of its privacy practices, as is required by the Federal Health Insurance Portability and Accountability Act (HIPAA). I understand that Bay Medical Family Practice will, upon request, provide me with a copy of the notice of privacy practice.

- By signing below, I am authorizing this physician and practice's staff to treat me for my medical condition.
- I authorize the release of my medical information to treating or referring physicians and to insurance companies or other pertinent parties to process payments.
- I authorize and request payment of medical benefits directly to my physician.
- I agree this authorization will cover all medical services rendered until such authorization is revoked by me in writing.
- I authorize the use of a fax in order to submit medical information to pertinent parties.
- I agree that a photocopy of this form may be used in lieu of the original.
- I understand that I am financially responsible for any balance that is not covered by my insurance carrier after 60 days.

Patient's Name	Signature of Patient Date
Signature of Responsible Party/Guarantor Date	Witness Date