

Notice of Privacy Practices: Patient Acknowledgment and Agreement

By signing below I hereby acknowledge that I have read, and fully understand Northside Family Medicine's Notice of Privacy Practices for Protected Health Information (HIPAA Agreement) and may ask for a copy if desired. Furthermore, we agree that at the discretion of Northside Family Medicine, Northside Family Medicine may release any information necessary to any member of my household or immediate family (sons, daughters, parents, spouses) unless I notify Northside Family Medicine otherwise.

Name of Patient (please print)

Date of Birth

Patient Signature

Date

PLEASE DO NOT RELEASE MY INFORMATION TO THE FOLLOWING PEOPLE _____

Assignment of Benefits

- 1) I understand that I am responsible for charges not covered or reimbursed by my insurance company(s). I agree that in the event of non-payment, to assume the costs of interest, collection, and legal action (if required).
- 2) I authorize my insurance carrier(s) to release information regarding my coverage to Northside Family Medicine. I also authorize agents of any hospital, treatment center, or previous physicians to furnish Northside Family Medicine copies of any records of my medical history, services, or treatments.
- 3) My right to payment for all procedures, supplies, and any other services including major medical benefits that are provided to me by Northside Family Medicine are hereby assigned to Northside Family Medicine. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance, and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services performed by Northside Family Medicine. In the event that my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Northside Family Medicine.
- 4) I understand I have a right to request and receive a Notice of Privacy Practices from Northside Family Medicine.
- 5) I hereby authorize Northside Family Medicine to inquire into my credit history if needed to obtain payment from me or confirm information that I have provided. It will only be done if I am not paying my bills as agreed upon above and will not be released to any outside agencies that are not directly involved in obtaining payment from me for services performed at Northside Family Medicine.

By signing below I have read the above statements and accept the terms and have been provided a copy of this statement if I have requested it.

Patient or Responsible Party Signature

Date

Online Communications Informed Consent: Patient Acknowledgment and Agreement

I acknowledge that I have read and fully understand the Online Communications Informed Consent form. I understand the risks associated with online communications between my physician and me. In addition, I agree to the instructions and restrictions outlined herein and that they may change without warning. I have had a chance to ask any questions that I had and to receive answers. Please notify us if you want a copy of our Online Communications Informed Consent. I realize that email that is being sent or received from Northside Family Medicine is not secure and could be read or intercepted by others. **FURTHERMORE, WHEN THE SECURE OPTION BECOMES EASIER TO USE WE MAY SEND ALL CORRESPONDENCE TO YOU VIA SECURE EMAIL.**

Signature

Date

your email address

Patient Guidelines: Patient Acknowledgment and Agreement

By signing below, I hereby acknowledge that I have read, and fully understand Northside Family Medicine's Patient Guidelines and agree to abide by the standards set therein. In addition to the instructions outlined therein, I agree to any other instructions that my physician may impose. I have had a chance to ask any questions that I had and to receive answers and have been provided a copy of the guidelines if requested.

Patient or Guardian Signature

Date

Patient Information

Today's date _____

Last Name _____ First _____ Middle _____

Soc. Sec# _____ - _____ - _____ DOB ____/____/____ Sex: M or F

Marital Status M S D W Sep How did you find our office? _____

Address _____ Apt# _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Mailing Address (if different) _____

Email address (Only include if you signed the Online communications informed consent) _____

Occupation _____

Employer Name and Address _____ Work Phone _____

Responsible Party for Billing Purposes _____

Parent or Legal Guardian Information
(to be filled out only if patient is a minor)

Last Name _____ First _____ Middle _____

Soc. Sec# _____ - _____ - _____ DOB ____/____/____ Sex: M or F

Marital Status M S D W Sep Relationship to patient: _____

Address _____ Apt# _____ Day Phone _____

City _____ State _____ Zip _____ Night/CellPhone _____

Employer _____ Occupation _____

Employer Address _____ Work Phone _____

Guarantor Information

If the insurance does not go through the patient, please give the information on who the insurance goes through:
or check here if same as above _____.

Last Name _____ First _____ Middle _____

Soc. Sec# _____ - _____ - _____ DOB ____/____/____ Employer _____

Address _____ Apt# _____ Day Phone _____

City _____ State _____ Zip _____ Night/CellPhone _____

Employer _____ Occupation _____

Employer Address _____ Work Phone _____

If for any reason insurance does not cover all or part of the visit, the patient, guarantor, or legal guardian, if a minor, is responsible for the balance.

Emergency Contact Persons

Primary Contact

Secondary Contract

Name: _____

Name: _____

Phone Number _____

Phone Number _____

Alt. Phone Number _____

Alt. Phone Number _____

Relationship _____

Relationship _____

If someone other than patient or patient's guardian is to receive any type of statement for payment to our office please provide the information below (as much as you have available)

Last Name _____ First _____ Middle _____

Soc. Sec# _____ - _____ - _____ DOB ____ / ____ / ____ Employer _____

Address _____ Apt# _____ Day Phone _____

City _____ State _____ Zip _____ Night/Cell Phone _____

Employer _____ Occupation _____

Employer Address _____ Work Phone _____

Relationship to Patient _____

Insurance Cards

Primary Card

Secondary Card

Date: _____

Please Write Name Here _____ Signature _____

REVIEW OF SYSTEMS Please answer the following questions by circling Yes or No- IF YOU HAVE TIME FILL OUT THE SOCIAL HISTORY AND HEALTH MAINTENANCE AREAS-

Any fevers or weight loss? YES NO

Any eye problems? YES NO

Any ear,nose, throat or mouth problems? YES NO

Any chest pain or irregular heart issues or swelling? YES NO

Any shortness of breath, coughing or wheezing? YES NO

Any nausea,vomiting, abdomen pain, or stool issues? YES NO

Any problems with urination in any way? YES NO

Any problems with your vagina or penis? YES NO

Any aches or muscle pains anywhere? YES NO

Any skin lesions, rashes or other problems? YES NO

Any breast problems? YES NO

Any weakness, numbness, dizziness, or tremors? YES NO

Any suicidal thoughts, sadness, depression, or anxiety? YES NO

Any bleeding problems anywhere? YES NO

Any runny nose, frequent sneezes or itchy eyes? YES NO

Any other concerns or questions you would like to discuss today? _____

Any Medications you need refilled today? _____

SOCIAL HISTORY

Tobacco Use? YES NO

Seat belt use? YES NO

Any Illicit Drug use? YES NO

How often do you drink alcohol? _____

HEALTH MAINTENANCE

Last Physical _____

Last Cholesterol _____

Last Prostate Check _____

Last Mammogram _____

Last Colonoscopy _____

Last Bone Density _____

Last test for blood in stool _____

Last Pap Smear _____

Do you have a living will? _____