EXPRESS FAMILY Care

Please present your **insurance card** and **photo ID** at check-in. Settlement of patient financial responsibility is expected at time of service.

Patient's Information (Please complete with Patient's Full Legal Name):

First: _____ M: _____ Last: _____

Birthdate: _____ Home Phone No: _____ Cell Phone No: _____

Street Address: _____ Apt. /Suite: _____

City: _____ State: _____ Zip: _____ Social Security No: _____

Gender: Male / Female Email Address: _____

Marital Status: S / M / D / W Preferred Contact: Home / Cell / Email

Pharmacy Information:

Pharmacy Name: _____ Location: _____ Zip Code: _____

Insurance Information:

Insurance Company: _____ Policy Number: _____

Group Number: _____ Copay Amount: _____ Effective Date: _____

Policy Holder: Self / Spouse / Parent / Other (**IF NOT SELF, PLEASE COMPLETE THE FOLLOWING**):

Policy Holder Name: _____ Birthdate: _____

If you have a **Secondary Insurance** plan, please complete the following:

Insurance Company: _____ Policy Number: _____

Group Number: _____ Copay Amount: _____ Effective Date: _____

Employer Information:

Employer Name: _____ Phone Number: _____

Emergency Contact:

Contact Name: _____ Phone Number: _____ Relationship: _____

In Case of emergency, do you allow the above person to receive your medical information? YES / NO

PLEASE SIGN CONSENT AND HIPAA SECTIONS ON BACK

CONSENT FOR TREATMENT / RELEASE OF INFORMATION

Consent for Treatment / Care:

I consent to treatment and care by Express Family Care physicians and health care providers. I am aware that no one has made any guarantees about the results of my treatments, examinations, or procedures. This consent will be effective for one year after the date it is signed; however, this consent will not expire for services or claims processing for visits occurring while this consent was in effect.

Consent for Use and Release of Information:

I give permission to Express Family Care to release any information about me, my health, the health services provided to me, or payment for my health services, that may be necessary for my treatment (to healthcare providers or facilities that need the information for my continued care), for any purposes related to payment by me or a third party for services (to determine eligibility, to process an insurance claim, for utilization and quality review, or for billing or collection purposes, as necessary to obtain payment); or for the health care operations of the other health care provider that has had a relationship with me. For more detailed information about the way my information may be used or released, I can read Express Family Care's privacy practices.

I give permission to Express Family Care to scan my image / take photographs or drawings of me for permissible treatment, payment, or health care purposes as long as consistent with policies and laws that protect my rights.

Financial Responsibility:

I understand that an insurance company may not pay the full amount of my charges, and I am responsible (as a patient, spouse, or the parent of a minor child) to Express Family Care for the amount not paid. If I do not have health insurance of have not provided current or accurate insurance information, I am responsible for payment of all charges. I agree if I have overpaid for any services, the overpayment may be applied to pay any outstanding charges on my, my minor children's, or my spouse's account(s).

Medicare/Insurance Assignment and Payment Request:

I authorize direct payment to Express Family Care to bill directly and assign the right to all health and liability insurance benefits otherwise payable to me. I have given my social security number voluntarily. I understand I may withdraw this consent in writing at any time. I authorize Express Family Care to release all records required to act on these requests. I have read and understand this form, received a copy if requested, and I am the patient or I am authorized to act on behalf of the patient to sign this form.

PATIENT / GUARDIAN SIGNATURE: _____ DATE: _____

HIPAA Patient Information:

By signing below, I acknowledge I have been presented with a copy of Express Family Care's Notice of Privacy Practices (HIPAA), detailing how my health information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice.

PATIENT / GUARDIAN SIGNATURE: _____ DATE: _____