**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:** (Please complete applicable fields as shown on card)

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 First **Full** Name: _____M:_____ Last: _____

Policy Holder's 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: _____

# Financial Authorization Form

## ASSUMPTION OF RESPONSIBILITY

I obligate myself, assume financial responsibility, and agree to pay upon demand to above named entity, all charges for such services and incidentals incurred. Even though insurance may be filed, I understand that all balance bills are payable upon receipt and that I, and not the insurance company, am responsible for the payment of all services. I understand that if my amount owed is not fully satisfied by the due date and my balance becomes delinquent, my account will be sent to a 3rd party collection agency. I understand that if the amount owed is sent to collections, an additional 35% of the outstanding balance will be added to the amount owed. You agree in order for us to service your account or to collect any amounts you may owe us, we may contact you by the telephone number assocation with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that Express Family Care, LLC may contact me/us as described above.

## COPAYMENTS

I agree to be fully responsible for paying co-pays of set amounts at the time of the physician visit. Further, I understand that if my co-pay is a percentage, I will be responsible for payment immediately after insurance benefits have paid. This meaning that any bill received once insurance is paid will be due upon receipt. If co-pays or deductibles are not received within 30 days of the patient statement date, professional fees are due in the total amount of charges and payable in full from you.

## NON-COVERED SERVICES / HMO POLICIES

I agree to be fully responsible for any care not paid for by my existing insurance coverage. I understand that payment is required in full at the time services are provided or upon notice of insurance claim denial. I understand that if I have an HMO policy, I am responsible for obtaining the referral needed for services rendered at Express Family Care for each individual visit I choose to be soon. I understand an HMO policy may not have benefits that cover EFC services and I am responsible for complete payment.

## PERSONAL INJURY CASE

This office does not bill for auto accident or other liability or lawsuit-related cases. Medical issues of any kind are filed through your medical insurance or discount payment services are available. It is up to you to follow up with outside entities regarding personal injury. You are responsible for payment at the time services are rendered.

## WORKER'S COMPENSATION

If your injury is work-related, we will need to notify worker's compensation eligibility with your employer prior to your visit. You must provide all workers compensation information related to your injury including but not limited to: injury date, workers compensation company name and phone number, claim number, claim filing address, etc.

## YEARLY HEALTH CHECKS

Preventative health checks, including annual physicals, may not be covered under your health insurance policy. Annual wellness exams are not available at this office. These are to be completed by your Primary Care Physican. School entrance physicals and sports physicals are cash pay only services. We do not provide immunizations at this office.

I understand, by signing this document, that payment be made and authorizes the release of medical information necessary to pay the claim. If “other health insurance” is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing information to the insurer or agency shown. Where benefits are assigned, the provider agrees to accept the charge determination of the healthcare carrier as the full payment, and the patient is responsible only for the deductible, coinsurance, and non-covered service as agreed by that patient's plan. Coinsurance and the deductible are based upon the charge determination of the healthcare carrier. I hereby authorize said assignee to release all information necessary to secure the payment. I have read, understood, and agree to the above.

Printed Patient Name: _____ Parent/Guardian Representative: _____

Patient's Signature: _____ Date: _____