PATIENT INFORMATION

PATIENT'S NAME____ ☐ MALE ☐ FEMALE
(LAST) (FIRST) (MI) (NICKNAME)

DOB _____/_____/_______ SOCIAL SECURITY #_______-______-_________ MARITAL STATUS: Single___ Married___ Other___

ADDRESS ____
(STREET) (CITY, STATE) (ZIP CODE)

HOME PHONE (_____) _______-_________ CELL PHONE (_____) _______-_________ WORK PHONE (_____) _____-_________

EMAIL ADDRESS_______________________________@___________________________

PHARMACY NAME________________________LOCATION______________________________

EMPLOYER ______________________________________ OCCUPATION______________________________________

NAME OF SPOUSE OR PARENT ___________________________

ADDRESS ______________________________________

____

____

EMERGENCY CONTACT INFORMATION:

NAME____

RELATIONSHIP______________ PHONE #_______________

REFERRING PHYSICIAN_____________________ FAMILY DOCTOR_______________________ PHONE # (____) _____-_______

INSURANCE INFORMATION – PRIMARY

INSURANCE CO. ____ POLICY # ____________________________

POLICY HOLDER NAME_________________________________ DOB ____/____/______ S.S. # _______-______-_______

INSURANCE INFORMATION - SECONDARY

INSURANCE CO. ____ POLICY # ____________________________

POLICY HOLDER NAME_________________________________ DOB ____/____/______ S.S. # _______-______-_______

I understand that I am financially responsible for all charges for services to me, including co-payments, co-insurance, out-of pocket, deductibles and non covered services. I authorize the payments from my insurance company(s) according to my medical benefits be made payable to Medical Associates of Brevard for professional services rendered. I understand that I will receive statements, reflecting my account balance and that the FINAL PAYMENT of this account is my responsibility. Furthermore, should I default on payment for services rendered I agree to pay all collection costs including reasonable attorney's fee. I authorize the disclosure of my medical information to all of Medical Associates of Brevard as well as to my insurance company(s).

LIFETIME SIGNATURE AUTHORIZATION: This signature and assignment is to be a continuing one, remaining in effect until revoked in writing by the undersigned. It signifies that all information given is current.

SIGNED ____ DATE ______/_______/_______

HIPAA RELEASE

I authorize Medical Associates of Brevard to discuss my health care information with:

____

(Name) **(Relationship)** **(Phone #)**

____

(Name) **(Relationship)** **(Phone #)**

SIGNED ____ **DATE** _____/______/______

I authorize Medical Associates of Brevard to leave a detailed message on my answering machine.

SIGNED ____ **DATE** _____/______/______

Notice of Privacy Practices

I acknowledge that I have received a copy of the Provider Notice of Privacy Practices for Medical Associates of Brevard. The Provider Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Provider Notice of Privacy Practices also describes my right and the responsibilities of duties of Medical Associates of Brevard with respect to my protected health information.

____

Print Name of Patient or Personal Representative

____

Signature of Patient or Personal Representative Date

____

Signature of Witness Date