PALM MEDICAL GROUP PATIENT INFORMATION

PATIENT INFORMATION

Last	First	M.I.	D.O.B.	Social Security Number
Maiden Name	Ethnicity/Race	Primary Language	Sex M F	Marital Status S M D W
Address Street			EMERGENCY CONTACT	Relationship
City	State	Zip	Home Phone ( )	Cell Phone ( )
Home Phone ( )	Cell Phone ( )		Employer	
			Name of your Primary Care Physician	Phone
			Name of physician who referred you to our office	Phone

PERSON RESPONSIBLE FOR BILL (OMIT IF SAME AS PATIENT INFORMATION)

Last	First	M.I.	Relationship	Social Security Number
Street			Employer	Occupation
City	State		Street	
Home Phone ( )	Cell Phone ( )		City	State Zip

INSURANCE INFORMATION

Primary Insurance

Insurance Company	Phone		
Insured's Name	Date of Birth		
Policy Number	Group Number		

Secondary Insurance

Insurance Company	Phone
Insured's Name	Date of Birth
Policy Number	Group Number

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that there is a new health care act (HIPAA – The Health Insurance Portability and Accountability Act) that serves to protect my personal health information. I have been given the opportunity to review Palm Medical Group's privacy practices and to take a copy of it home with me if I would like. I understand that my personal health information is important to the associates of Palm Medical Group, and that they will not misuse my personal health information in any way.

CONSENT FOR TREATMENT

I hereby authorize and consent to diagnostic testing and treatment as ordered by my physician. I authorize Palm Medical Group's physicians, nurses, medical assistants, employees and others as necessary, to carry out the instructions of my doctor with respect to the procedures and treatment he has ordered.

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the physician or group indicated on the claim. I understand that I am responsible for any deductibles, co-payments or amounts for services not covered by my insurance plan. All professional services rendered are charged to the patient, or guarantor, if a minor. In the event of collection proceedings due to lack of payment, there may be additional charges for any and all collection fees. A copy of the signature is as valid as the original.

Signature of Patient (or legal representative) Relationship Date