MIDTOWN FAMILY MEDICINE

NEW PATIENT FORM

Which doctor are you here to see? (Please circle one): Dr. Montoya / Dr. Ortiz / Angela Lovell, PA-C

Patient's Name_____ Sex ☐ M ☐ F
Patient's Date of Birth: _____/_____/_____ SSN*_____/_____/_____*REQUIRED
Ethnicity: ☐ Hispanic or Latino ☐ NOT Hispanic or Latino ☐ OTHER_____
☐ Refused to Provide Ethnicity
Home Telephone Number: (_____) _____ Cell Number: (_____) _____
Mailing Address: _____
City: _____ State: _____ Zip code: _____
Employer: _____ Work Number: (_____) _____
Spouse's Name: _____ Phone Number: (_____) _____
Pharmacy Preference: Name/Location and Phone #_____
Language Preference*:_____*IF OTHER THAN ENGLISH
Email Address: _____

RESPONSIBLE PARTY INFORMATION (If patient is under the age of 18)
Name: _____
Relationship to Patient: _____
Date of Birth: _____/_____/_____ SSN*_____/_____/_____*REQUIRED
Mailing Address: _____City: _____State: _____Zip code: _____
Employer: _____ Work Number: (_____) _____

INSURANCE INFORMATION
Primary Insurance: _____
Subscriber's Name: _____Date of Birth: _____/_____/_____
Subscriber SSN: _____/_____/_____* * IF other than patient.
Subscriber relationship to patient: ☐ SPOUSE ☐ PARENT ☐ OTHER_____

Secondary Insurance: _____
Subscriber's Name: _____Date of Birth: _____/_____/_____
Subscriber SSN: _____/_____/_____* * IF other than patient
Subscriber relationship to patient: ☐ SPOUSE ☐ PARENT ☐ OTHER_____

EMERGENCY CONTACT
Name: _____Phone Number: (_____) _____
Relationship to Patient: _____

I certify that all the information given by me is correct to the best of my knowledge.
I agree to notify Midtown Family Medicine of any changes to my contact and insurance information.

Signature: _____ **Date:** _____/_____/_____

***This information is required to process medical insurance claims, for medical services you receive.**

Midtown Family Medicine

Consent to Treat and Insurance Assignment Policy

Consent to Treat

Consent is hereby given to Midtown Family Medicine, its staff, its contractors, and its employees to provide medical services and to administer physician orders, retrieve and review my medical record/electronic medical record which includes my medication list and other medical information necessary to facilitate electronic prescribing.

I certify that all the information given by me which includes my name, address, telephone number, and insurance information are correct to the best of my knowledge and that I am authorized to inform Midtown Family Medicine of any changes immediately.

I hereby authorize Midtown Family Medicine to furnish information to insurance carriers, referring physicians, and other healthcare agencies concerning illness and treatment with respect to services rendered.

Insurance Assignment Policy

Our office is pleased to accept your insurance assignment, as soon as your exact coverage is verified. We will file your claim forms and assist you in every way we can. **However, it must be fully understood that the contract is between you and your health insurance company and you are fully responsible for any amount not paid by your insurance.** Office policy regarding insurance assignment:

1. Your insurance should pay within 30 days. If your insurance has not paid within 60 days, you may be responsible for the balance, and be reimbursed when and if your insurance pays.

2. Our office does NOT guarantee that your insurance will pay. We will make every attempt to receive insurance payment. However, if for some reason, your insurance claim is denied, you are responsible for the FULL amount of your bill.

3. Our office will NOT enter into a dispute with your insurance company over a claim. This is your responsibility and obligation.

I assign all payment for services rendered to MIDTOWN FAMILY MEDICINE. I understand and agree that I am responsible for all charges whether or not covered by my insurance.

Patient Signature: _____Date: _____

Responsible Party: **_____Relationship_____**

Midtown Family Medicine

Patient Appointment Responsibility and Insurance Assignment Policy

Patient Appointment Responsibility

The Doctors and Staff of Midtown Family Medicine commit to provide you with careful and attentive healthcare. It is important for you to keep your appointment(s) so that we can maintain continuity in your healthcare. If you are unable to keep your appointment please call us at least 24 hours in advance so that we can offer your cancelled appointment to another patient.

If you do not keep your appointment:

1. Your patient record will be noted if you do not keep an appointment and you do not notify our office
2. After three (3) missed appointments in a 12 month period, the physician can consider terminating you from Midtown Family Medicine.

I have read and understand my responsibility to keep my appointments.

Patient Signature_____ **Date**_____

Acknowledgement of Receipt of Notice of Privacy Practices

By my signature below, I acknowledge that I have read the **"NOTICE OF PRIVACY PRACTICES".** This notice describes how MIDTOWN FAMIY MEDICINE:

- may use and disclose my protected health information,
- and certain restrictions on the use and disclosure of my healthcare information,
- and rights I may have regarding my protected healthcare information.

Patient Signature_____**Date**_____

Authorized Person Signature_____**Relationship**_____