

PATIENT INFORMATION FORM

Referred by: _____ Primary Care Physician: _____
 Last Name: _____ First Name: _____ Prefix Mr. Mrs. Miss Ms. Dr.
 Middle Name: _____ Preferred Name: _____
 Date of Birth: ____/____/____ Age: _____ SSN: _____ - _____ - _____
 Address: _____ City: _____ County: _____ State: _____ Zip: _____
 Email Address: _____ Home: () _____ - _____ Cell: () _____ - _____ Work: () _____ - _____

May we leave a message about appointments or normal test results on the phone numbers you provided? Yes No
 Would you like to receive appointment reminders via text message on your cell phone? Yes No
You consent to receive text messages from us that may contain health information or advice. You are not required to provide consent in order to receive such information or advice from your provider. Standard text messaging rates may apply.

Alternate Contact: If you want us to contact you at an alternate address or telephone number, please provide below:
 Alt. Address: _____ City: _____ State: _____ Zip: _____ Phone: () _____ - _____

Marital Status: Married Single Separated Divorced Widowed Partner Unknown
Ethnicity: Not Hispanic / Latino Hispanic / Latino Declined to Specify
Race: White Black / African American Asian American Indian / Alaska Native
 Native Hawaiian / Other Pacific Islander Declined to Specify Other Race
Birth Sex: Male Female **Gender Identity (optional):** _____
Sexual Orientation (optional): Straight/heterosexual Lesbian Gay/homosexual Bi-sexual Choose not to disclose Other
Primary Language: English Spanish French Other: _____
Student Status: N/A Full-time Part-time **Employment Status:** N/A Full-time Part-time **Employer:** _____
Name of Pharmacy: _____ **Address:** _____ **Phone:** () _____ - _____
Emergency Contact Name: _____ **Relationship:** _____ **Phone:** () _____ - _____

Guarantor/ Person Financially Responsible For the Payment of Healthcare Services If Other Than The Patient

Last Name: _____ Mr. Mrs. Miss Other: _____ Sex: Male Female
 First Name: _____ Date of Birth: ____/____/____ Age: _____ SSN: _____ - _____ - _____
 Middle: _____ Relationship to Patient: _____ + _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home: () _____ - _____ Cell: () _____ - _____ Work: () _____ - _____
 Email Address of Guarantor/ Person Financially Responsible: _____

Primary Insurance

Insurance Company: _____
 Policyholder Name: _____
 Member or Policyholder ID #: _____
 Policyholder Date of Birth: _____
 Insurance Co. Phone #: _____
 Group #: _____
 Relationship to Patient: _____

Secondary Insurance

Insurance Company: _____
 Policyholder Name: _____
 Member or Policyholder ID #: _____
 Policyholder Date of Birth: _____
 Insurance Co. Phone #: _____
 Group #: _____
 Relationship to Patient: _____

Consent for Treatment, Authorization, Assignment of Benefits, and Referral Release

CONSENT FOR TREATMENT: I consent and authorize Roper St. Francis Physician Partners (“RSFPP”) physician or designated qualified assistant to provide me medical treatment and to use and release my protected health information for treatment, payment, and healthcare operations as allowed by HIPAA and as described in the RSFH Notice of Privacy Practices, a copy of which has been made available to me.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I understand that my medical information, including complete medical records, test results, and billing information, may be released to my insurance company and to other medical professionals and/or medical care institutions for treatment and payment purposes.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign all my rights and allow payment to be made directly to RSFPP for all medical or surgical benefits otherwise payable to me under terms of my insurance.

PAYMENT GUARANTEE: I understand and agree that I am responsible for paying all co-payments, co-insurance, deductibles, and non-covered services rendered by RSFPP, including charges for services not covered by my insurance. I consent and authorize RSFPP and third party agents of RSFPP to contact me by telephone at any number associated with me, including a wireless number, and to use a pre-recorded and/or an automatic dialing service in connection with any communication made to me or related to my account.

A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian’s responsibility to keep RSFPP informed of changes to my contact information; a failure to do so may interfere with the ability to contact me concerning my healthcare.

This consent for treatment, authorization, assignments of benefits and referral release is valid for one year from date signed.

Print Patient’s Name: _____

Patient’s Signature: _____

Date: ____ / ____ / ____

Print Legal Guardian’s Name: _____

Legal Guardian’s Signature: _____

Date: ____ / ____ / ____

Ongoing Communication Regarding Your Healthcare

ONGOING COMMUNICATION: DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL(S) WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITIONS? IF YES, TO WHOM?

By listing an individual and/or entity below, you authorize ALL RSFPP physician offices to release and/or discuss your health information with the individual and/or entity you have listed. You may list a specific date range or an event or choose all health information.

Beginning date or event to be released: _____ End date or event to be released: _____ Or all healthcare information _____

Authorized Individual or Entity	Phone Number	Relationship	Address
_____	(____) _____	_____	_____
_____	(____) _____	_____	_____

*Any revocation or modification to your authorization regarding an individual or organization must be submitted in writing.

** A separate **Authorization to Release Information Form** must be completed to release and/or discuss your health information with any individual(s) and/or entity(s) not listed in the section above. *Authorization is not required for treatment purposes.*

*** To request restrictions of the use and disclosure of your information, you must complete a separate **Request to Restrictions Form.**

Prescriptions

For your convenience, please specify any individuals you authorize to pick up your prescriptions from RSFPP provider(s).

Name of Individual	Phone Number	Relationship	Address
_____	(____) _____	_____	_____
_____	(____) _____	_____	_____