Medical Insurance Intake Form

What is your primary concern/goal?_____

Last Name:_____Middle Initial:_____First Name:_____

D.O.B:_____Sex:_____Race:_____**Social Security:**_____-_____-_____

EMAIL for Appt Reminders:_____Occupation:_____

Height:_____Weight:_____Blood Pressure:_____

Street:_____City:_____State:_____Zip code:_____

Daytime phone:_____Mobile:_____Work:_____

Emergency Contact:_____Phone:_____Relation:_____

List any medication(s), Supplement(s), you are currently taking. **(WE CAN MAKE A COPY OF YOUR LIST)**

_____

_____

Preferred Pharmacy:_____

Specify any known Allergies & Reactions (Ex: Penicillin=Hives)_____

Tobacco use: **Y** or **N** Alcohol use: **Y** or **N** Illicit Drugs use: **Y** or **N**

Past Medical History: _____

Past Surgical History: _____

May we leave a confidential message on our home/cell phone machine, if you are not available? ()**Y** ()**N**

PLEASE COMPLETE FOR INSURANCE OR MEDICAL APPOINTMENTS ONLY

Primary Care Provider/Referring Physician:_____

Responsible Insurance Party: First Name:_____ Last Name:_____

TRICARE ONLY-**Sponsor Social Security:**_____-_____-_____Relationship to Patient_____

Primary Insurance & Policy Number:_____

Secondary Insurance & Policy Number:_____

Please read the following statement and sign below:

I affirm that I have informed all responsible parties of known physical and mental conditions and medications. I affirm that I will keep responsible parties updated on any changes in my medical profile. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Signature:_____ **Date**:_____

Consent Form

Dear Patient, our practice is required to have various consent forms in your record to be able to provide you with medical care. These include: permission for whatever treatment, assignment of benefit, release of information, and insurance coverage waiver. As a convenience to you we have covered all of these necessary items in this one-page document. Your signature below acknowledges your understanding of all of them.

Consent to Treat

I (or my legal guardian/parent) authorize CFA to provide medical care reasonable by today's standard.

Assignment of Benefits

I hereby assign to CFA any insurance or other third-party benefit available for health care services provided to me. I understand that CFA has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to CFA, I agree to forward to CFA all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

Consent to Release Information

I authorize CFA to release all medical information (including, but not limited to, information on psychiatric condition, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier or any other third-party payers. I authorize CFA to release all information to my referring doctor and any doctors they may consult, as well as to my primary physician. I authorize CFA to contact my insurance company or health plan administrator to obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to CFA.

Insurance Coverage Waiver

I understand that my eligibility for coverage by my insurance provider(s) cannot be confirmed at this time.

I wish to receive medical care from CFA. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

Patient Name:_____

Patient Signature:_____ **Date:**_____

FINANCIAL POLICY

This statement describes our financial agreement between you the patient/guardian and our practice.

Patients over the age of 18 will be held responsible for their medical bills with our practice. Parents/guardians of patient under the age of 18 will be held responsible for their medical bills with our practice. To help us provide the most efficient and reasonable health care services, it is necessary for us to have a Financial Policy stating our requirements for payment of services provided to our patients. Patients are responsible for the payment of all services provided by our office. It is our policy to file for insurance as a courtesy to you if we have **accurate** and **complete** insurance information. All benefits information we obtain for you is an **estimate** only of your cost, and is subject to change.

Since we are not a party to the agreement between you and your insurance company, we ask that you assist us in contacting them in the event that services are not paid within 30 days. Co-pays and deductibles are expected at the time of service. If we do not participate in a plan with your insurance company, we will still file with your insurance carrier. However, you will be responsible for payment at the time of service. If we receive duplicate payment from the insurance company, we will then refund any overpayment to you. All services that an insurance company determines to be non-covered, or for any remainder due after our office receives a payment or denial from your insurance company will be your responsibility. All balances are expected to be paid in full upon billing receipt. If you **do not have insurance**, you will be considered a **"SELF-PAY"** patient and will be required to pay **$250.00** for your **initial consultation** and will be responsible for any additional treatments/procedures charges as well. We can complete medical disability and Family Medical Leave Act (FMLA) forms. We require 5 business days to complete them. A $25.00 fee will be charged for this service. There's also a fee to copy medical records. Patient "NO SHOWS" and cancellations are a tremendous loss for our practice. Please help our office reduce those losses by canceling within 24 hours if you cannot keep your appointment. **Failure to give notice prior to your appointment will result in a $25.00 fee to be paid by the patient/guardian. We will bill your insurance for the "NO-SHOWS" but you will be responsible for any that are not covered.** We accept cash, major credit cards, debit cards, cashier's checks.I agree to adhere with the financial agreement outlined above.

Patients name:_____

Patients signature:_____ **Date:** _____