ANMED HEALTH
PATIENT INFORMATION

IMPORTANT NOTICE

Due to HIPAA requirements, this form must be filled out completely.
Please ask for help if you have questions about any field.
We will be unable to file insurance for incomplete forms. Thank You.

PATIENT INFORMATION

Full Name:				Name you wish to be called:			
Social Security #:		Date of Birth:		Age:		Gender:	
Mailing Address:		City, State:				Zip:	
Home Phone #:		Cell #:		**Email Address:**			
Language Preference:	Patient Parent/Guardian			**Highest Grade Level Completed:**	Patient Parent/Guardian		

Employment Status:	**Student Status:**	**Marital Status:**	**Race:**	**Ethnicity:**	**Learning Preference:**
☐ Full Time ☐ Part Time ☐ Self ☐ Retired ☐ None	☐ Full Time ☐ Part Time ☐ None	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	☐ American Indian / Alaska Native ☐ Asian ☐ Native Hawaiian / Oth. Pacific Islander ☐ Black / African American ☐ Unknown ☐ White ☐ Declined	☐ Hispanic / Latino ☐ Non-Hispanic / Non-Latino ☐ Unknown ☐ Declined	☐ No Preference ☐ Verbal ☐ Visual ☐ Written

Employer/School Name:			Work Phone #:		
Employer Address:		City, State:		Zip:	
Emergency Contact Name & Phone #:					
Family Physician's Name:		Referring Physician's Name: (if applicable)			
I authorize the following people access to my protected health or medical information: (Please list name & relationship to patient):					
Do you have Advanced Directives? YES NO If yes choose type: __ Health Care Power of Attorney/Living Will __ DNR					
Preferred Pharmacy Name and Location:					

Primary Insurance Information:	**Secondary Insurance Information:**
Subscriber Name:	Subscriber Name:
Date of Birth:	Date of Birth:
Social Security Number:	Social Security Number:
Name of Insurance:	Name of Insurance:
ID Number:	ID Number:
Relationship to Patient:	Relationship to Patient:
Employer of Insured:	Employer of Insured:

CONSENT TO TREAT, BENEFIT ASSIGNMENT, RELEASE OF INFORMATION AND FINANCIAL POLICY

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment as ordered by a physician and certify that the insurance information listed above is correct and that all insurance benefits for services rendered are directly assigned to this AnMed Health physician practice site. I understand that I am financially responsible for all charges regardless of benefits. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance claim submissions. Should this account be turned over to a collection agency for collection, I understand and agree that I will be obligated to pay all collection costs, including, but not limited to, reasonable attorney's fees.

The policy of AnMed Health Physician Practice Network is that the patient has the ultimate responsibility for payment of his/her account. Payment is due at the time services are rendered unless specific arrangements have been made prior to treatment. Our network does participate with a number of insurance plans. Please contact your insurance company to verify participation. If we participate with your insurance carrier, you will be expected to pay your portion of the charge and/or a predetermined co-pay amount on the date of service, and we will file your insurance claim. We will allow a period of forty-five (45) days from the filing date for your carrier to process and pay your claim. If your claim has not been paid within that period, full payment of the charges, as well as any follow-up with the insurance company becomes your responsibility.

If we do not participate with your insurance carrier, we will file your claim as a courtesy, but you will be responsible for any out of network fees and co-insurance amounts at the time of service.

If we refer you to a specialist or schedule procedures/tests, we will try to send you to a facility that participates with your insurance. Ultimately, it is your responsibility to contact the insurance company to confirm the provider is in the network and the procedure/test is authorized.

If you are not covered by an insurance plan, payment in full will be expected at the time of service. If this creates a financial hardship for you, please inform the receptionist before services are rendered so that satisfactory arrangements for payment can be made.

Signature of Patient or Legal Guardian _____ Printed Name of Patient or Legal Guardian _____ Date _____

Time: _____