Southside Medical Care

CONFIDENTIAL PATIENT INFORMATION SHEET
(PLEASE PRINT)

Date: _____

ADULT PATIENT DATA:

PATIENT: (LAST NAME) _____ (FIRST) _____ (MI) _____

STREET ADDRESS: _____ UNIT/APT # _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____)_____WORK PHONE: (_____)_____ EXT: _____

CELL: (_____)_____ SOCIAL SECURITY #: _____–_____–_____

DATE OF BIRTH: _____/_____/_____ AGE: _____ SEX: ____MALE ____ FEMALE

EMAIL ADDRESS: _____

HOW DID YOU HEAR OR HOW WERE YOU REFERRED TO OUR FACILITY: _____

MARITAL STATUS: ____ SINGLE ____ MARRIED ____ DIVORCED _____ SEPERATED _____ WIDOWED

EMPLOYER'S NAME: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____ CITY: _____ STATE: _____ ZIP _____

SPOUSE'S NAME: _____ WORK TEL#: (_____)_____ EXT: _____

SPOUSE'S EMPLOYER: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT: (LAST)_____ (FIRST) _____

RELATIONSHIP _____ HOME TEL #: (____)_____

WORK TEL #: (_____)_____ CELL #: (_____)_____

INSURANCE: PLEASE PRESENT ALL INSURANCE CARDS TO FRONT DESK FOR PHOTOCOPYING EACH VISIT.

PRIMARY INSURANCE CO. NAME: _____ ID #: _____ GROUP #: _____

POLICY HOLDERS NAME : _____ RELATION TO PATIENT: _____

STREET ADDRESS:_____ UNIT/APT #_____

CITY: _____ STATE: _____ ZIP: _____

POLICY HOLDERS SOCIAL SECURITY #: _____–_____–_____ DOB: _____/_____/_____

SECONDARY INSURANCE CO. NAME: _____ ID#: _____ GROUP #: _____

POLICY HOLDERS NAME: _____ RELATION TO PATIENT: _____

POLICY HOLDERS SOCIAL SECURITY #: _____–_____–_____ DOB: _____/_____/_____

PLEASE LIST NEAREST RELATIVES NOT LIVING WITH PATIENT OR OTHER FAMILY AND FRIENDS:

NAME: (LAST) _____ (FIRST) _____ RELATION: _____

HOME TEL # (_____)_____ WORK TEL #: (_____)_____ EXT:_____

CELL #:(_____)_____

MEDICAL CONSENT- ASSIGNMENT OF BENEFITS - RELEASE OF INFORMATION

I HEREBY, UNDERSIGNED AUTHORIZE THE **PHYSICIANS, PHYSICIAN ASSISTANTS AND/OR NURSE PRACTIONER** AND STAFF OF SOUTHSIDE MEDICAL CARE TO PROVIDE MEDICAL CARE FOR THE ABOVE NAMED PATIENT.

I ALSO, CONSENT TO THE RELEASE BY SOUTHSIDE MEDICAL CARE OF ANY AND ALL MEDICAL INFORMATION NECESSARY TO PROCESS ANY AND ALL INSURANCE CLAIMS ON MY BEHALF.

I HEREBY WITH MY SIGNATURE ASSIGN AND AUTHORIZE MY INSURANCE CARRIER (S) TO MAKE PAYMENT DIRECTLY TO SOUTHSIDE MEDICAL CARE FOR ALL SERVICES RENDERED.

SIGNATURE OF PATIENT _____ DATE: _____

FINANCIAL UNDERSTANDING

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED. WE ACCEPT CASH, CHECK, DEBIT, VISA, MASTER CARD, AMERICAN EXPRESS AND DISCOVER.

IN ORDER TO HONOR INSURANCE BENEFITS, YOU MUST PROVIDE YOUR CURRENT HEALTH INSURANCE CARD EACH TIME YOU VISIT OUR OFFICE.

IF YOUR INSURANCE PLAN REQUIRES A PRIMARY CARE PHYSICIAN, OUR PHYSICIAN'S NAME/PRACTICE NAME MUST BE LISTED ON YOUR INSURANCE CARD. IF WE ARE NOT LISTED AS YOUR PRIMARY CARE PHYSICIAN YOU MAY PAY FOR SERVICES OUT OF POCKET OR YOU MAY RESCHEDULE YOUR APPOINTMENT WHEN YOU HAVE CHOSEN ONE OF OUR PHYSICIAN'S/MEDICAL PRACTICE AS YOUR PRIMARY CARE DOCTOR.

IF YOU BELONG TO A MANAGED CARE INSURANCE PLAN, ALL APPLICABLE FEES ARE DUE AT THE TIME OF SERVICES. PLEASE REFER TO YOUR CO-PAY SCHEDULE.

IF YOUR INSURANCE COMPANY HAS A DEDUCTIBLE AND YOU HAVE NOT YET MET THE DEDUCTIBLE YOU WILL BE RESPONSIBLE FOR PAYMENT AT THE TIME SERVICES ARE RENDERED.

OUR OFFICE SUBMITS THE MAJORITY OF CLAIMS ELECTRONICALLY TO YOUR INSURANCE COMPANY WITHIN 24 HOURS OF YOUR VISIT. MOST INSURANCE COMPANIES SEND PAYMENT TO US WITHIN 23 BUSINESS DAYS. YOUR INSURANCE COMPANY SENDS TO YOU AN EXPLANATION OF BENEFITS STATING WHAT YOUR PATIENT RESPONSIBILITY IS FOR YOUR CLAIM. FROM THE EXPLANATION OF BENEFITS YOU KNOW THE EXACT AMOUNT YOU OWE TO SOUTHSIDE MEDICAL CARE AND WE ASK THAT YOU REMIT PAYMENT WHEN YOU RECEIVE THIS INFORMATION FROM YOUR INSURANCE COMPANY.

WHEN YOU COME TO THE OFFICE FOR AN APPOINTMENT AND THERE IS A BALANCE ON YOUR ACCOUNT WE REQUIRE PAYMENT OF THAT BALANCE AT THE TIME OF SERVICE.

THERE WILL BE A $35.00 FEE FOR ANY CHECK OR DRAFT DISHONORED BY ANY FINANCIAL INSTITUTION.

IN THE EVENT OF COLLECTION PLACEMENT OF MY ACCOUNT I UNDERSTAND I WILL BE CHARGED A LATE FEE OF $25.00 IN ADDITION TO THE BALANCE SUBJECT TO THE COLLECTION.

I HEREBY WITH MY SIGNATURE, UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT IN FULL OF ALL SERVICES RENDERED IN THE EVENT MY INSURANCE CARRIER AND/OR MANAGED CARE PLAN DENIES PAYMENT IN FULL OR PART OF ANY SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO ALL COPAYMENTS, DEDUCTIBLES, NON COVERED SERVICES AND SUPPLIES OBTAINED DURING THE COURSE OF CARE.

SIGNATURE OF PATIENT _____ DATE: _____