Seton Family of Doctors

Patient Information

Today's Date:____________________

GUARANTOR/BILLING INFORMATION

First Name: ______________________________ M.I.____ Last Name: ____

Address: ____

City: ______________________________ State: ____________________ Zip Code: ________________________________

Home Phone: __________________________Work Phone: ________________Cell Phone__________________________

Email address___________________________

PATIENT INFORMATION

First Name: ______________________________ M.I.____ Last Name: ____

Address: ____

City: ______________________________ State: ____________________ Zip Code: ________________________________

Home Phone: _____________________________ Emergency Phone: ____

Date of Birth: ____________ Sex: [ ] F [ ] M SSN: __________________ Marital Status__________________________

Primary and/or Referring Physician Name:______________________________Phone:________________________________

Patient's Employer Name: ____

Address: ____ City: ______________________________ State: ___________

Zip Code: _________________________________ Phone Number ____________________________ext_________________

PRIMARY INSURANCE INFORMATION

Insurance Company: ____

Policy Number: ____ Group Number: ____________________________

Relationship to patient:: 1:Self 2:Spouse 3:Child Policy Holder Name: ____

Address: ____ City: ______________________________ State: ___________

Zip Code: ____________ Phone Number ____________________________ Date of Birth: __________________________

Employer Name: _________________________________ Employer Address: ______________________________________

City: ______________________State: ____ Zip Code: __________ Phone Number_________________ext___ ___________

SECONDARY INSURANCE INFORMATION

Insurance Company: ____

Policy Number: ____ Group Number: ____________________________

Relationship to patient:: 1:Self 2:Spouse 3:Child Policy Holder Name: ____

Address: ____ City: ______________________________ State: ___________

Zip Code: ____________ Phone Number __________________ Date of Birth: ___________________________

Phone Number ____________________________ext_________________

Seton Family of Doctors

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE AND RECORD OF DISCLOSURE

The HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI).

I understand that as part of my health care, Seton Family of Doctors originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, as well as plans my future care or treatment.

I understand that as part of Seton Family of Doctors treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity for the purposes stated above.

I certify that I understand the privacy risks of the mail, phone calls, and email. I hereby authorize a representative or my physician to mail, call, or email me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying the Seton Family of Doctors in writing.

Patient/ Parent Signature ____Date ________________

Print Name ____Birth date of patient ______________

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

I give permission to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

____ Relationship ___________________________

____ Relationship ___________________________

____ Relationship ___________________________

____ Relationship ___________________________

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices

I certify that I have received and read a copy of the Patient Information Privacy Policy.

Signature of Patient/Legal Guardian _______________________________________Date __________________

(To be completed if patient refuses to sign acknowledgement)

Date____________________ Name of person providing notice _______________________________________

Seton Family of Doctors

Patient Authorizations

Our primary mission is to provide you with quality, cost effective, medical care.
It is important that we have a good understanding with our patients regarding financial responsibility.
We hope this summary will be helpful in explaining your responsibility and the expectations in maintaining a positive Seton Family of Doctors and patient relationship. We encourage you to ask questions if you do not understand any area.

Please understand that financial responsibility for medical services rest between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan.

- Co-payments and applicable deductibles are due at the time of service unless other arrangements have been made with our office.
- If you are uninsured, or if the services being provided are not covered by your insurance, you will be expected to provide payment in full at the time they are rendered.
- If you receive a payment from your insurance in error, please bring it along with any paperwork to our office.

1. **Authorization to Release Information**
   I hereby authorize Seton Family of Doctors to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination and treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing

2. **Assignment of Insurance Benefits/Patient Financial Responsibility**
   I hereby authorize direct payment of my insurance benefits to the Seton Family of Doctors for services rendered to my dependents or me by Seton Family of Doctors providers or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Seton Family of Doctors is unable to collect from my insurance carrier for whatever reason.

3. **Medicare/ Medicaid/Insurance Benefits**
   I request that payment from Medicare/ Medicaid or any other insurance carrier, be made on my behalf to Seton Family of Doctors I authorize the release of any of my or my dependent's records that these programs may request. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid and its agents or insurance company any information needed to determine these benefits payable for related services.

4. **Lab/ X-Ray/ Diagnostic Services**
   I understand that I may receive a separate bill if my medical care includes lab, x-ray, or diagnostic services. I also understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for what ever reason.

5. **Teaching Institution**
   I understand that Seton Family of Doctors includes teaching facilities and therefore I may be attended to by students and residents of various disciplines and affiliated with various educational programs. I understand that I may request and receive information on the specific affiliation(s) of any particular healthcare provider I encounter during my care

6. **Consent to Treatment**
   I hereby consent to evaluation, testing, and treatment as directed by my physician or his or her designee.

________________________________ Date of Birth_______________ ______________________
Patient/Responsible Party Signature Date

________________________________ ______________________
Witness Date