PATIENT INFORMATION~

Today's Date:________________

Patient Name:____ Nickname:________________
(last) (first) (middle initial)

Social Security#:____/___/____ Patient Birthdate: ___/___/____ Sex: Male Female

PERMANENT
Address or PO Box:______________________________ City:______________State:____Zip:_________

Race: White African American Indian Asian Other Ethnicity: Not Hispanic Hispanic
Primary Language: English Spanish Other _________________________

Marital Status: Married Single Widow Divorced Student: Full time Part time ☐ N/A

Please place an X by your primary phone number

☐ Home Phone:(___)_____-________ ☐ Work Phone:(___)_____-________ ☐ Cell Phone:(___)_____-________

E-mail Address:_______________________________

Employer:______________________________ Phone _____________ Full Time Part Time Retired
Address _______________________________City_______________State _________ Zip_____________

~**Emergency Contact**~
Name:____ Relationship:______________________
Home Phone:(____)_____-_______ Cell Phone:(____)_____-_______ Work Phone:(_____)_____-_______

Additional Information required **(only if the patient is a minor) or STUDENT**

Mother	**Father**
Name:______________________	**Name:**______________________
Address:______________________	**Address:**______________________
City:______________ **State:**_____	**City:**______________ **State:**_____
Zip:_____________	**Zip:**_____________
Home phone:___________ **Cell:**___________	**Home phone:**___________ **Cell:**___________
Date of Birth:______________________	**Date of Birth:**______________________
Social Security #______________________	**Social Security #**______________________
Employer:______________________	**Employer:**______________________

Minor Resides with: ☐ **Mother** ☐ **Father** ☐ **Guardian**

~**Primary Insurance**~ ****Please present all insurance cards to the Receptionist****

Insurance Company:____________________________________ Office Visit Co-Payment:$______

Name of Policy Holder/Insured:__________________________ Insured Date of Birth:____/___/_____

Relationship to Patient:_______________ Social Security #:____/___/____ Effective: ____/____/_____
Employer:________________________________

~**Secondary Insurance**~ (if applicable)

Insurance Company:____________________________________ Office Visit Co-Payment:$______

Name of Policy Holder/Insured:__________________________ Insured Date of Birth:____/___/_____

Relationship to Patient:_______________ Social Security #:____/___/____ Effective: ____/____/_____
Employer:________________________________

Who is your Family Physician?:____

STATEMENT OF RESPONSIBILITY - The patient is responsible for notifying our office of any changes in address, telephone number(s), or insurance information. If the office is unable to contact you because of outdated or incorrect information, we cannot take responsibility for your care.

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. Please remember that your insurance policy is a contract between you and your insurance carrier. Co-payments are due at the time of service. Patients without insurance are expected to pay at the time the service is rendered.

Co-pays are due at the time of your service. *Falcon Health Center / Wood Health Company* **charges a $10.00 fee for co-pays not paid at the time of service**.

No Show Appointments - .Our office reserves the right to charge a $50.00 No Show Fee if you fail to keep your appointment.

Returned Check (NSF) - If you present a check that is returned to Wood Health for non-sufficient funds, a $25.00 fee will be charged to your account.

If your visit is the result of an **auto-accident**, we will not file the claim to your medical insurance carrier. *Falcon Health Center / Wood Health Company* does not get involved with third-party litigation. As with any balance, the responsibility resides with the guarantor of the account. We will supply an itemized bill at your request.

Work related injuries - are referred to Wood County Hospital Occupational Health department (ReadyWorks).

Minors - the responsibility for the balance remains with the parent and/or legal guardian of the patient.

Referrals - It is your responsibility to obtain a referral if required by your insurance plan. You must know and utilize the facility that is covered by your insurance carrier. We are not responsible for any charges incurred for not following the rules set forth by your insurance plan.

Authorization and Assignment of Benefits -. I authorize release of all medical information necessary to process insurance claims on my behalf. I authorize the assignment of benefit payment to which I am entitled to *Falcon Health Center / Wood Health Company*. **This assignment of benefits will remain in effect until revoked by me in writing.** A photocopy of this assignment is to be considered as valid as the original.

Consent for Treatment - I consent for treatment by the providers and staff of *Falcon Health Center / Wood Health Company*. **This consent for treatment will remain in effect until revoked by me in writing**. A photocopy of this assignment is to be considered as valid as the original.

Patient Name:____________________(Print) Patient Date of Birth:__________

✓ ***Patient Signature***: ____________________ Date:__________

✓ ***Responsible Party Signature***:____________________ Date:__________

Relationship to Patient:____________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have reviewed a copy of the Notice of Privacy Practices of *Falcon Health Center / Wood Health Company* and understand that my protected health information may be used by the Practice as described in the Notice.

✓ ***Patient Signature***:____________________ Date:__________

Consent to Release of Information-Required if you would like us to discuss your healthcare with someone other than you.

The HIPAA Privacy Regulations require that we obtain your consent to discuss your healthcare or financial information related to your care. **The right to disclose information to the below noted individual(s) will remain in effect until revoked in writing, by you.**

Spouse:	Yes	No	Spouse Name:__________
Child	Yes	No	Child/Children Names:__________
Other:	Yes	No	Name-Relationship__________
Electronic data:	Yes	No	E-mail address:__________

✓ ***Patient Signature***:____________________ Date:__________