People's Clinic

PATIENT INFORMATION

Mr. Ms. Mrs. Dr . **Patient Last Name**:_____ **First**:_____ **Middle Initial**: _____

Male____Female____Social Security #_____Married____Single____Widow____Divorced____D.O.B.: _____

Race: Decline ☐ White ☐ Asian ☐ Black or African ☐ American ☐ Indian ☐ Native ☐ Hawaiian ☐ Other ☐
Ethnic Group: Decline ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐

Address: _____
Street City State Zip

Phone (H)_____Phone (Cell)_____Phone (Work)_____Ext. _____

Email:_____Driver's License #_____Date expired:_____State_____

Preference of way to be contacted: Phone ☐ Text ☐ **Patient Portal**: **Yes** ☐ or **No** ☐

Policy Holders Primary Insurance Information: Name of Ins. Company: _____

Policy Holders Name:_____Date of Birth:____/____/____Social Security #: _____

Relationship to you:_____Employer:_____ID#_____Group # _____

Secondary Insurance Information: Name of Ins. Company: _____

Policy Holders Name:_____Date of Birth:____/____/____Social Security #: _____

Relationship to you:_____Employer:_____ID#_____Group# _____

How did you hear about us?_____Who was your previous primary care provider? _____

In case of an emergency, whom do we contact? Name:_____Relationship to you:_____

Emergency contact phone: 1st#_____/ 2nd#_____Address: _____

What pharmacy do you get your prescriptions filled at?_____Which location:_____

Employment Information:

Place of Employment:_____Full time ☐ Part time ☐ Retired ☐
Co. Name Address

Spouse's Place of Employment:_____Full time / Part Time
Co. Name Address ☐ ☐

Financial Agreement (Please Read and Sign Below)

- Payment Policies: I hereby authorize direct payment of surgical/medical benefits to Dr. Gary W. Cole and/or other medical practitioners within this practice for services rendered by him in person or under his supervision.
- I understand that I am financially responsible for any balance not covered by my insurance. We allow a reasonable amount of time for your insurance company to pay for treatment.
- I hereby authorize Dr. Cole and/or other medical practitioners within this practice to release any medical or incidental information that may be necessary for either medical care or in processing applications for financials for financial benefit.
- I certify that the information given by me in applying for payment is correct. I authorize release of all records on request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be as valid as the original. This office cannot accept responsibility for collecting your denied insurance claim or dispute its settlement.
- I Cancellation Policy: Patients are expected to notify the office at least 24 hrs prior to schedule appointments time. Failure to notify us in advance can result in a no show charge to your account. Three missed appointments may result in dismissal from the practice. Five (5) minutes late to your appointment is considered a No Show and may result in a $75.00 fee and your appointment may be rescheduled. Please arrive early to avoid this.
- Advanced Care Plan: An Advanced Care Plan (Living Will) is available to every patient age 18 or above or to a parent caring for an emancipated minor.
- FOR MEDICARE PATIENTS ONLY CERTIFICATION FOR PAYMENT - I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about myself to be released to the Social Security Administration or it intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf; I assign the benefits payable for physician services to the provider furnishing the services, or authorize such provider to submit a claim to Medicare for payment to me.

Acknowledgement of Receipt of Notice of Privacy Practices (HIPPA)

***** I HAVE READ, UNDERSTAND AND HAVE ACCESS TO A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICE *****

Patient Name (please print)_____Patient/Guardian Name: _____

Signature:_____**Date**: _____