

Welcome!

Patient Information

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ Home Phone _____
Last Name First Name Initial

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: M F Minor Single Married Long Term Partner Divorced Widowed Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Additional Insurance

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Assignment and Release

I hereby authorize payment directly to _____ of all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____



CONSENT FOR TREATMENT/ DISCLOSURE & PAYMENT AGREEMENT

Patient's Name: _____

Medical Record #: _____

(1) Thank you for choosing us as your healthcare providers. We feel strongly that all patients deserve the very best medical care available and we are honored to be able to provide it. Please consent to be evaluated for medical treatment by the health care provider(s) of **Vibrance Internal Medicine**. ____ Initial ____ date

(2) **Disclosure** – I have been offered a copy of the Notice of Privacy Practices and/or had it explained to me. I understand this Notice and have had the chance to ask questions about any matters I don't understand. ____ Initial ____ date.

(3) **Payment** – I agree, in consideration of the services being rendered to me, I am hereby individually obligated to pay my account with Vibrance Internal Medicine in accordance with its regular rates and terms. If, signing as a representative, a parent or guardian, or otherwise legally responsible person for the patient, I agree to the obligation described herein. Payment of all co-pays, deductibles, coinsurance, and other amount not covered by insurance is due at the time of service.

Patients without insurance coverage: Payment in full is expected at the time of your first visit. Payment plan is available for follow up appointments. ____ Initial ____ date

(4) **Missed Appointments:** If you are unable to keep an appointment with our practice, please notify us at least 24 hours in advance of your appointment. Failure to do so may result in a \$40.00 charge to your account. All missed appointment fees must be paid prior to your next visit. Exceptions may apply !

Payment Options: We accept cash, Visa, Master Card, and Care Credit only. We do not accept personal checks. ____ Initial ____ date

(5) I consent for **Vibrance Internal Medicine** to communicate with a designated member other than my emergency contact, _____ (name) _____ (relationship), _____ (phone) regarding my health information and payment related to my care.

I have read and understand the consent for treatment, disclosure, and payment agreement of this office and agree to abide this policy.

Patient/Responsible Party

Date

For Staff Use Only

The following good faith efforts were made to obtain acknowledgement; however, acknowledgement was not obtained because: _____

Staff Signature: _____

Date: _____

(Please turn form over and complete other side)


Medical Spa. Internal Medicine. Wellness Center

Patient Information Sheet

Patient's Name: _____

Sex: _____ Date of Birth: _____ Marital Status: _____ SS#: _____

Mailing Address: _____
City State Zip Code

Home Phone (): _____ Cell Phone: () _____

Please check one: May we leave a message at your home if you are unavailable? Yes No

Referred to our office by: _____ Email address: _____

Employer Information

Employer: _____ Work Phone: () _____

Employer's Address: _____
City State Zip Code

Emergency Contact Information

Name: _____ Relationship: _____

Telephone #: () _____ Cell Phone #: () _____

Insurance Information

Self Pay (please check one): Yes No

Insurance Carrier Name: _____ ID #: _____ Group #: _____

Please present picture ID and Insurance card to receptionist.

Patient Authorization:

I hereby authorize the release of any information to my insurance carriers that was acquired during the course of my examination and treatment. I hereby authorize the payment of medical benefits directly to the physician and I understand that I am responsible for any amount not covered by my insurance.

Patient's Signature: _____ Date _____

(Please turn form over and complete other side)