**Masonboro Family Medicine**

**Please complete all sections:**

**Patient full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male/Female Date of Birth: \_\_\_\_\_\_\_\_\_ Marital status: \_\_\_\_Primary Language: \_\_\_\_\_\_\_\_\_\_Race: \_\_\_\_\_ Refused Ethnicity: Hispanic/ Non-Hispanic Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Address: Responsible Party if other than Patient Mailing Address**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Primary Contact Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Secondary Contact Phone Number: \_\_\_\_\_\_\_\_\_\_ Contact Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Full time/ Part time/ Retired/ Student Employer Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**In case of emergency call: (1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_**

 **(2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_**

**Primary Insurance Information Secondary Insurance Information**

**Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy Holder/Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder/Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy Holder Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ASSIGNMENT AND RELEASE OF INFORMATION**

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and compliance resolutions. I authorize payment directly to MASONBORO FAMILY MEDICINE, P.C. for all medical and surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. I understand that while MASONBORO FAMILY MEDICINE, P.C. will make every effort to notify me that a service may not be covered by my insurance, I agree that I will be financially responsible for any services considered not covered by my insurance. A photocopy of this authorization shall be considered as effective and as valid as the original.

**May we leave normal lab results on your answering machine/ voice mail/ cell phone? YES / NO**

**Besides yourself, who may we discuss your medical information (including lab & x-ray results) billing information**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MFM REQUIRES A COPY OF YOUR MOST RECENT INSURANCE CARD TO FILE YOUR INSURANCE. WITHOUT A CURRENT INSURANCE CARD WE WILL BE UNABLE TO FILE YOUR INSURANCE AND YOU WILL BE RESPONSIBLE FOR ALL CHARGES AT THE TIME OF SERVICE. COPAYS ARE DUE AT TIME OF SERVICE.**

**Patient or Responsible Party Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**