Family Care Clinics

Your Affordable Healthcare Solution
www.FamilyCareClinics.net

Patient General Information

Last Name: ________________________________ First Name: ________________________

Date of Birth MM/DD/YYYY: _______/________/_________ Age: _________ Sex: M/F

Patient SSN: ______________________________ Marital Status: Single Married Divorced

Race(s): ____

Patient E-mail address: ____

Home Phone: ___________________________ Mobile Phone: _________________________

Home Address:

Street: ____ APT#: ___________

City: ________________________________ ST: _____________________ ZIP: _____________

Mailing Address/Insurance Billing Address:

Street: ____ APT#: ___________

City: ________________________________ ST: _____________________ ZIP: _____________

Emergency Contact

Name _________________________________ Phone Number ________________________

Pharmacy ______________________________ Phone Number _______________________

May we contact you by PHONE☐ E-MAIL☐ MAIL☐ NEWSLETTERS☐?

Is it ok to mail Specialist Referrals to your address? Yes/No Home Address/Mailing Address

How did you learn about us? ____

Reason for Visit ____

Primary Care Physician Name: ____

Location: ____ Phone: ____________________

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Are you employed: Yes /No /Retired/Student **Type of work**: ______________________

Employer/School Name: ______________________________Phone: __________________

Street: _________________________City: ____________________ST: ____ ZIP: __________

Primary Insurance Traditional☐ HMO☐ PPO☐ Medicaid☐ Medicare☐ Other☐

Company: ____________________________________Phone: _________________________

Insurance ID#: _______________________Group Number: __________________________

Secondary Insurance Traditional☐ HMO☐ PPO☐ Medicaid☐ Medicare☐ Other☐

Company: ____________________________________Phone: _________________________

Insurance ID#: _______________________Group Number: __________________________

Financial Policy

Today you will be responsible for full payment or your co-payment plus the cost of any other services not covered by insurance.

If you have insurance, you will file today's charges with your insurance company.

Before Treatment, you must present 1. Your Insurance Card 2. A valid Gov't Issued ID.

If Family Care Clinics has a contract with your insurance company, you will be responsible for your co-payment and the cost of any services not covered by insurance. You may receive a bill from Family Care Clinics for any unpaid balance.

If you do not have insurance coverage, or Family Care Clinics does not have direct contact with your insurance company, or cannot verify your eligibility, you will be required to pay in full for your visit today. You can expect to make a minimum payment of **$80,** which will be collected today. If your treatment requires more complex evaluations, labs, X-rays, or supplies, you will be charged for those in addition to the appropriate office visit fee. These fees will be collected after service and treatment have been provided.

Notice of Privacy Practices

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Your name and signature below indicate that you have reviewed Family Care Clinics' Notice of Privacy Practices. If you have and questions, you may contact Family Care Clinics at (972) 242-4440.

Name (Print): ____

Signature: ____Date: ____________

Release of Medical Records, Assignment of Benefits, Financial Responsibility

I authorize Family Care Clinics to submit claims to my insurance carrier as well as medical records needed to evaluate these claims for payment. I further authorize payments of benefits, otherwise payable to me, to be made payable to Family Care Clinics. I understand that I am financially responsible for all charges not covered by my insurance. If my insurance company is not in Family Care Clinics' network or I have no insurance coverage, I understand that I am financially responsible for all charges and must make full payment today.

Signature of Patient/Guardian: _____________________________ Date: ____________

Authorization and Agreement for Medical Treatment

I give permission to Family Care Clinics to perform the medical and surgical processes, treatment, and/or procedures that the physician and other non-physician providers and assistants may deem to be necessary. In addition, I authorize Family Care Clinics to release any information obtained during the course of my examination and/or treatment to my health care insurer or other payer. I agree that I am financially responsible to Family Care Clinics for charges resulting from my receipt of such medical and surgical processes, treatment, and/or procedures.

Signature of Patient/Guardian: _____________________________ Date: ____________