PROHEALTH PARTNERS PATIENT INFORMATION SHEET

PATIENT INFORMATION (*please print*)

First Name: ______________ Middle Initial: ______ Last Name: ______________

Home Address : ______________ City: ______ State: ______ Zip Code: ______

Billing Address (if different): ______________

Work Address (if different): ______________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Preferred Contact # ______________ Email Address ______________

Drivers License # ______________ Date of Birth: ______________ Social Security # ______________

Sex: ❑ M ❑ F Marital Status: ❑ S ❑ M ❑ D ❑ W ❑ Other: How did you hear about us? ______________

Primary Care Physician: ______________ Primary Language: ______________

Race: ______________ Ethnicity (circle one) Hispanic or Latino Not Hispanic or Latino

Employer: ______________ Employer Phone: ______________ Occupation: ______________

Emergency Contact: ______________ Relationship: ______________ Phone: ______________

GUARANTOR / PARENT / INSURED INFO (SEND BILL TO):

Guardian Last Name (if applicable): ______________ First: ______________ Initial: ______

Date of Birth: ______________ Social Security # ______________ Relationship: ______________

Employer: ______________ Address: ______________ Phone: ______________

INSURANCE INFORMATION

Primary Insurance: ______________

Policy Holder Name: ______________ DOB: ______________ Social Security # ______________

Billing Address: ______________ City, State, Zip: ______________

Group or Policy # ______________ Cert. or Member # ______________ Local Union # ______________

Co-Pay Amount: ______________ Policy Effective Dates: From: ______________ To: ______________

Patient Relation to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other: ______________

Secondary Insurance: ______________

Policy Holder Name: ______________ DOB: ______________ Social Security # ______________

Billing Address: ______________ City, State, Zip: ______________

Group or Policy # ______________ Cert. or Member # ______________ Local Union # ______________

Co-Pay Amount: ______________ Policy Effective Dates: From: ______________ To: ______________

Patient Relation to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other: ______________

PHARMACY INFORMATION

Pharmacy Name: ______________ Address: ______________ Phone: ______________

Signature (Patient or Parent of Minor): ______________ Date: ______________

FINANCIAL POLICY

AGREEMENT TO PAYMENT POLICY: I acknowledge that I received a copy of PROHEALTH PARTNERS, INC. financial policy and agree to the terms of payment due.
AUTHORIZATION TO RELEASE INFORMATION: I authorize release of my medical record information, pursuant to applicable federal and state law, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state and local laws. I further authorize any other individual or entity that has provided health care to me to release to PROHEALTH PARTNERS, INC., any and all of my medical records information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.
ASSIGNMENT OF BENEFITS: I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to PROHEALTH PARTNERS, INC. for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.
GUARANTEE OF PAYMENTS: I agree to pay all applicable charges, which are not paid in full by my insurance. If amounts due to PROHEALTH PARTNERS, INC. are not paid according to this financial policy, the account shall be deemed delinquent. In the event that I default on payment of my account, I understand I am responsible for any and all cost incurred on the collection of my account, including court cost and reasonable attorney's fee. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amount in default.

______________________________ ______________________________

Patient Signature Date Responsible Party Relationship to Patient