PATIENT INFORMATION

First Name ________________________________ Last Name ____________________________ MI ___

SS# _______-______-________ DOB ______/______/______

Mailing Address ____ City _____________ State ____ Zip _________

Street Address (if different from mailing) ___________________ City _____________ State ____ Zip _________

Home Ph(_____)_______________ Cell Ph(_____)________________ Work Ph(_____)_______________

May we leave a message? ☐ Yes ☐ No If yes, where? ☐ Home ☐Cell ☐ Work

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☐Male ☐Female ☐Refuse to Respond ☐ Single ☐ Married ☐ Divorced

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Race: ☐ Asian ☐ Black or African American ☐ White ☐ Other Race
Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino
Language: ☐ English ☐ Spanish ☐ Other _______________

Employer ____ Phone #(_____)___________________

Mailing Address ____ City _____________ State ____ Zip _________

Are you a student: ☐ Yes ☐ No ☐ Full-time ☐ Part-time

Responsible Party (if patient under 18 years)____

Signature of Responsible Party_______________________________ Relationship to patient__________________

Mailing Address ____ City _____________ State ____ Zip _________

SS # _______-_______-_______ DOB ______/______/______ Phone # (___)_______________

Employer ___________________________Occupation __________________Phone # (_____)______________

Primary Insurance ___________________________

Policy Holder Name ___________________________

Policy Holder DOB ________/______/________

Policy Holder Social Security #______-____-______

Relationship to Patient _________________________

Subscriber ID # _______________________________

Group # _____________________________________

Secondary Insurance ____________________________

Policy Holder Name ____________________________

Policy Holder DOB ________/_______/________

Policy Holder Social Security #______-____-______

Relationship to Patient __________________________

Subscriber ID # ________________________________

Group # _____________________________________

CASSIE HEALTH CENTER

Primary Care Provider ____

Address ____ City _______________ State ____ Zip _________

Phone # ________________________________ Fax # ______________________________________

Emergency Contact ____

Address ____ City _______________ State ____ Zip _________

Home/Cell Phone # ________________________________ Work # ______________________________

Relationship to Patient ____

Pharmacy ____

Address ____ City _______________ State ____ Zip _________

Phone # _____________________________________ Fax # _______________________________

Do you have a power of attorney? _____ yes _____no If yes, we need a copy of the legal document.
Do you have a legal guardian? _____ yes _____no If yes, we need a copy of the legal document.

CASSIE HEALTH CENTER

OUR PRACTICE FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service. Your understanding of our financial policy is an essential element of your care and treatment. If you have any questions, please feel free to discuss them with our staff.

INSURANCE

It is my responsibility to inform CHC if I have a primary insurance under someone else's name. It is my responsibility to notify CHC when my insurance has changed to a different plan or a different carrier. If any claims deny for this reason or CHC finds that I have primary insurance, I will pay the balance in full to CHC and will personally file the claim(s) to my insurance carrier.

__________ Initials

Our office does not participate with all insurance plans. It is my responsibility to know if CHC is a participating provider with my insurance company. CHC will file a claim on my behalf to my insurance carrier. CHC will collect any co-payments, co-insurance, and/or deductibles at the time of service. **If I do not have my payment at the time of service, CHC may re-schedule my appointment for another day**. In the event my insurance denies a claim for any reason, I am responsible for the complete charge. Payment will be due upon receipt of statement.

__________ Initials

It is also my responsibility to call my insurance for confirmation of coverage for my office visit and/or procedure.

__________ Initials

My insurance policy is a contract between myself and the insurance company and not CHC. CHC will do their best to work with my insurance carrier, but I am ultimately responsible for all charges incurred.

__________ Initials

I understand that any outstanding balances that I may incur must be paid in full prior to my next appointment.

__________ Initials

It is my responsibility to check if my insurance carrier is contracted with CHC and/or any outside facility that CHC uses for my care.

__________ Initials

CASSIE HEALTH CENTER

SELF-PAY

As a self-pay patient, I am required to pay at least half of the office visit cost. A payment plan can be set up with the Billing Department for the remaining balance. A 20% discount will be applied when the balance is over $100.00 and paid in full on the same date of service.

__________ Initials

Failure to adhere to our financial policy can result in dismissal from the practice and delinquent account information will be reported to our collection agency. All cost incurred for collections will be charged directly to you.

SLIDING FEE

We offer a sliding fee scale for patients who do not have insurance. Based on household income you can qualify for a discount on your visits with us **provided we receive the necessary documents required**. Applications are available at the front desk.

PAYMENT PLANS

We offer comfortable and flexible payment plans to fit your budget. Inquire with our billing department for more information.

CASSIE HEALTH CENTER

HIPAA NOTICE OF PRIVACY PRACTICE

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. You may reference the document posted for details. Please ask the front office for the location.

Signature below is an acknowledgement that you have received this Notice of our Privacy Practice.

AUTHORIZATION FOR RELEASE OF PRESCRIPTION HISTORY

I grant permission for Cassie Health Center obtain all prescription history from external sources as needed.

Signature below is an acknowledgement that you have granted permission.

INSURANCE AUTHORIZATION

I hereby authorize Cassie Health Center to furnish information to my insurance carrier(s) concerning my illness and treatments. I hereby assign the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not paid by my insurance. The Guarantor (must be over 18 years of age), is responsible for payment(s) for all services rendered to minor patients.

I have read and understand the financial policy of the practice and I agree to be bound by its terms.

CASSIE HEALTH CENTER

____
Print Name

____
Signature

____
Date

Cassie Health Center is required by law to furnish information to other Physicians, Attorneys, Insurances, etc.

AUTHORIZATION FOR RELEASE OF INFORMATION

This authorization is if you wish for any of your family members, friends, etc., have access to your appointments, test results and/or financial status, etc.

Date:____________________

My self only: ______________________________ DOB: ________________
(Patient Name) (Patient Date of Birth)

Or

I, ____ authorize Cassie Health Center to release information, medically and/or financially to the following person (s):

________________________________ ______________________________
Name Relationship

_________________________________ ______________________________
Name Relationship

I understand that Cassie Health Center will release information to you and the names(s) listed above only. I also understand that I am responsible for updating or revoking the form as necessary, **in person and in writing.**

___________________________________ __________________________
Signature of Patient or Guardian Date

CASSIE HEALTH CENTER