# PATIENT INFORMATION FORM

(PLEASE PRINT)

PATIENT'S NAME: _____
(Last) (First) (MI)

SEX: Female_____Male_____ BIRTHDAY: _____ SOCIAL SECURITY #:_____

ADDRESS: _____ CITY:_____STATE:_____ZIP CODE:_____

HOME PHONE :(____)_____ WORK :(____)_____ CELL:( ____)_____

EMAIL ADDRESS: _____ [ ] Decline

LANGUAGE: _____ RACE:_____ or Decline to answer ETHNICITY_____ or Decline to answer

MARITAL STATUS: _____ NAME OF SPOUSE/PARTNER:_____

**How would you like us to contact you? Home Phone Work Phone Cell Phone Mail or Patient Portal**

**Would you like to be contacted by someone with our offices regarding the customer service you received at your visit? (no information regarding your visit will be asked, strictly your customer service experience) _____YES _____NO**

**Who referred you to our practice? (circle one) Family/Friend Primary Care Physician Specialty Physician Insurance Plan TV Newspaper Billboard Radio Internet Yellow Pages Healthy Woman Event Senior Circle Event Hospital Employer**

**Do you have an Advance Health Care Directive (living will)? ____YES ____NO**

**Are you a member of the following? Healthy Woman? ____YES ____NO Senior Circle? ____YES ____NO**

---

## PRIMARY INSURED INFORMATION (If different from above)

NAME:_____RELATIONSHIP:_____ BIRTHDATE:_____SOCIAL SECURITY #:_____

ADDRESS: _____CITY:_____STATE:_____ZIP CODE:_____ PHONE :(____)_____

---

## GUARANTOR INFORMATION

This portion is for whoever is legally responsible for the patient and any medical issues or expenses that may arrive.

NAME: _____ BIRTHDAY: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ CITY: _____STATE:_____ZIP CODE: _____ PHONE :(____)_____

## EMERGENCY CONTACT

NAME:_____RELATIONSHIP:_____ PHONE(____)_____CELL (____)_____

NAME:_____RELATIONSHIP:_____ PHONE(____)_____CELL (____)_____

---

**PATIENT SIGNATURE:**_____ **DATE:**_____

**PARENT/GUARDIAN SIGNATURE ( If under 18 ):**_____

# FINANCIAL POLICY

We strongly feel all patients deserve the very best medical care that we can provide. Everyone benefits when financial arrangements are agreed upon. We have prepared this material to acquaint you with our policy. Our professional services are rendered to you, not the insurance company. Payment for treatment is your responsibility.

## FINANCIAL AGREEMENTS

Initial

_____ I have no insurance coverage. I understand that I am responsible for payment of services rendered to myself or dependents **at the time of service.**

Services rendered maybe eligible for a Sliding Fee scale. If you have no Insurance coverage and would like to see if you qualify we have Financial Forms that you will need to complete and return to the front office staff.

_____ I understand if I fail to pay amounts owed; the clinic has the right to secure an outside collection agency and/or attorney to collect the unpaid debt and to report the unpaid debt to a credit-reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collection agency or attorney, including reasonable attorney's fees.

## INSURANCE AUTHORIZATION AND ASSIGNMENT

Initial

_____ I hereby authorize Moberly Medical Clinics, Inc. to release information acquired during the course of my examination and treatment to the Health Care Financing Administration and its agents, or any other third party as necessary to secure payment of any benefits due me. I hereby assign to Moberly Medical Clinics, Inc., any insurance or other third-party benefits available for health care services provided to me. I understand that Moberly Medical Clinics, Inc. has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Moberly Medical Clinics, Inc., I agree to forward to Moberly Medical Clinics, Inc. all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

_____ I understand I am responsible **at the time of service** for paying any required co-payment and deductible.

---

## MEDICARE SIGNATURE OF FILE ASSIGNMENT OF BENEFITS { For Medicare Patient only}

_____ _____

Name of Patient HIC #

_____ _____

Name of Medigap Insurer MEDIGAP POLICY #

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME ON MY BEHALF OR TO MOBERLY MEDICAL CLINICS, INC. FOR ANY SERVICES FURNISHED ME BY THAT PROVIDER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE CENTERS FOR MEDICARE & MEDICAID SERVICES AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES

I REQUEST PAYMENT OF AUTHORIZED MEDIGAP BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO MOBERLY MEDICAL CLINICS, INC. FOR ANY SERVICES FURNISHED TO ME BY THAT PHYSICIAN/SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE ABOVE NAMED MEDIGAP INSURER ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

_____ _____

Patient Signature Date

---

**There will be a $ 25.00 charge on all returned checks.**

**I HAVE READ AND UNDERSTAND THE PAYMENT POLICY OF THIS OFFICE AND AGREE TO ABIDE BY THE SAID POLICY.**

_____ _____

Patient/Parent/Guardian Date

# CONSENT FOR TREATMENT and PHOTOGRAPH
## AUTHORIZATION FOR MEDICAL TREATMENT

I the undersigned, a patient of the Moberly Medical Clinics, Inc., hereby request and authorize the Practice and its personnel to administer such medical treatments as necessary, including, but not limited to, any photographs that may need to be taken for my medical care.

**Patient's Name** **(PLEASE PRINT)** **Date of Birth**

**Signature of Patient or Legal Guardian** **Date**

**Witness** **Date**

---

Complete the following **ONLY** if the patient is a minor or has a legal guardian

The above patient:
( ) Does have my permission
( ) Does not have my permission

To be seen and treated without being accompanied by his/her legal guardian or parent for this visit and And any and all future visits. I understand that I will be responsible for the bill, should insurance not pay, even if I am not present at the time of the patient's visit.

Name of person allowed to accompany patient Relationship to patient

Name of person allowed to accompany patient Relationship to patient

Name of person allowed to accompany patient Relationship to patient

Signature of Parent or Legal Guardian Date

If there are any special parental or custodial relationship (such as custody with one parent only, legal custody/guardians with no parents, etc.) please explain in the space below with your signature, printed name and phone number at which you can be contacted.

Signature Printed Name

Contact Number

## Patient Consent for E-Prescribing (Electronic Prescribing)

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

| Parent, Patient's Signature or Authorized Representative | Date | Time |
|---|---|---|
| Relationship to Patient | Interpreter, if utilized | |
| Witness' Signature | | |