GRAHAM FAMILY MEDICINE

Date: _____

Patient Information

Patient Name: _____
Last First MI

Social Security #: _____ Birth Date: _____

Address: _____
Street Apt #

_____
City State Zip Code

Phone (Home): _____ (Work): _____ (Cell): _____

Race: ☐ African American ☐ Alaskan ☐ Asian ☐ Caucasion ☐ Hispanic ☐ Native Indian/ Alaskan

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Widowed

Email: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Emergency Contact

Name: _____
Last First MI

Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Home Phone: _____

Relationship: _____

Employment Information

Employer Name: _____ Phone #: _____

Phone #: _____ Fax #: _____

Referral Physician

Physician/Practice Name:
_____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

GRAHAM FAMILY MEDICINE

Insurance Information

Primary

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID #:___ _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: (Circle One) Self Spouse Child Other

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID #:___ _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: (Circle One) Self Spouse Child Other

Insurance Plan Name and Address: _____

Patient Payment Guarantee: I do hereby guarantee payment in full of any and all charges, which are not payable by my HMO/PPO with which Eric S Graham, MD, Abigail Summer, APN and Graham Family Medicine Inc., has contracted, in consideration for medical services rendered, or to be rendered to above named patient. Further, I agree to pay all attorney fees and costs incurred by Eric S Graham, Abigail Summers, and Graham Family Medicine, Inc. in the collection of amounts for which I am responsible.

Patient or Guardian Signature: _____ Date:_____

If Guardian, give relationship to patient: _____

GRAHAM FAMILY MEDICINE

CONSENT FOR TREATMENT

I request and authorize Health Care Services by my physician, and his/her designees may deem advisable. This may include routine diagnostic, radiology and laboratory procedures and medication administration.

_____Date:_____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENATIVE

ASSIGNMENT OF MEDICAL BENEFITS OTHER THAN MEDICARE

I hereby assign transfer and set over to Graham Family Medicine all of my rights, title and interest to my medical reimbursement benefits under my insurance policy for any services furnished me by them. I understand I am financially responsible for any balance not covered by my insurance carrier.

_____ Date: _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENATIVE

MEDICARE ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Graham Family Medicine for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to Graham Family Medicine and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ Date: _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENATIVE

COMMUNICATIONS AUTHORIZATION

Graham Family Medicine, its physicians and staff, are authorized to use telephone message systems to aid communication with me, or my authorized representative, regarding my treatment, appointments, financial arrangements, and in response to any request I have initiated.

_____ Date: _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENATIVE

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Graham Family Medicine, its physicians and staff, are authorized to share information and provide copies of my entire medical records, including all written and oral reports, substantive evaluations of progress, history, diagnosis, prognosis, course of treatment, reports, and attendance and compliance with respect to all care or treatment, including all confidential HIV and AIDS related information, mental health records, drug and alcohol, abuse treatment records, sexual assault and sexual abuse counseling records to my insurance companies, doctors, treating facilities, and my employer in the case of Worker's Compensation, and the following persons:

Spouse Name _____ Parents, if over 18 Names _____

Children Names _____

_____

Authorized Representative Name _____

Other Names _____

_____ Date: _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENATIVE

NOTICE OF PRIVACY PRACTICES (HIPAA)

If you did not receive these documents, or have misplaced them, please ask for another copy. This signature page is in reference to the Federal HIPAA Privacy Regulations requirements. The undersigned certifies that he/she has received a copy of the Notice of Privacy Practices (HIPAA), and is the client, or is duly authorized by the client as the client's representative. If a more detailed verbal explanation is needed, in addition to the one you received, please request one now and we would be pleased to assist you.

_____ Date: _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENATIVE

I HAVE READ AND UDERNSTAND THE ABOVE ASSIGNMENTS AND AUTHORIZATIONS TO USE/DISCLOSE HEALTH INFORMATION ABOUT THE NAMED PATIENT AS DESCRIBED. THESE ASSIGNMENTS/AUTHORIZATIONS REMAIN IN AFFECT UNTIL REVOKED BY ME IN WRITING.

A copy of any or all above signatures is as valid as the originals

GRAHAM FAMILY MEDICINE

Medical History Form II (PART 2)

NAME: _____

ILLNESS	SELF (YES)	SELF(NO)	FAMILY(YES)	RELATIONSHIP
Diabetes				
High Blood Pressure				
Kidney Disease				
Heart Disease				
Lung Disease				
Thyroid Disease				
Hepatitis				
High Cholesterol				
Peptic Ulcer				
Asthma				
Cancer				
Seizures				
Stroke or TIA				
Migraine				
Anxiety/Depression				
Mental Illness				
Other				

GRAHAM FAMILY MEDICINE

Name:_____ **DOB:**_____ **Date:**_____

Medication Allergies:

Drug:_____ **Reaction:**_____

Drug:_____ **Reaction:**_____

Drug:_____ **Reaction:**_____

Drug:_____ **Reaction:**_____

*Additional:*_____

Current Medications:

Drug:	Dosage:	Time of day:	Prescribing Doctor:
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____
5._____	_____	_____	_____
6._____	_____	_____	_____
7._____	_____	_____	_____
8._____	_____	_____	_____
9._____	_____	_____	_____
10._____	_____	_____	_____
11._____	_____	_____	_____
12._____	_____	_____	_____
13._____	_____	_____	_____

Additional:_____

_____

GRAHAM FAMILY MEDICINE

Additional Fees

COMPLETION OF ADDITIONAL FORMS: Any forms requested for physician completion requiring a review of the patient chart by the physician, will have a charge of **$15-$30**, depending on the extensiveness of physician time and needed paperwork.

MEDICATION REFILLS: Patients who need refills before 5:00 pm, on the same day as their request, will be charged a fee of **$10.** This charge must be paid by the patient prior to receiving the refill.

MEDICAL RECORDS: Patients requesting a copy of their full medical chart will be charged a copy fee of **$25.** All other records requests will result in varying processing fees. For clarification, you may speak with the office manager.

RETURNED CHECK FEE: All personal checks returned to Graham Family Medicine for insufficient funds will encounter a **$35 Returned Check Fee**. This charge, in addition to the amount of the returned check, is due *immediately* and will require payment by cash or credit card.
NOTE: Patient payments from this point forward must be made by cash or credit card.

NO CALL/NO SHOW (MISSED) APPOINTMENTS; Failure to notify Graham Family Medicine at least 24 hours prior to the occurrence of a missed appointment is considered a No Call/No Show. After two (2) No Call/No Show appointments, patients will be charged a **$25** fee. Repeated incidents may result in dismissal from the practice. **No Call/No Show Procedure Appointments** will automatically incur a charge of **$50** upon the first occurrence. *These charges can NOT be billed to your insurance company and is, therefore, the patient's responsibility.*

By signing below, I acknowledge I am aware of Graham Family Medicine's policies regarding additional fee charges, which may be incurred, during and/or after treatment. I acknowledge I am responsible for the above stated charges and agree to remit payment when necessary.

_____ _____

Signature of Patient or Authorized Representative *Date*