PATIENT INFORMATION SHEET

PLEASE PRINT

Social Security # _____ - _____ -_____ **Date:** _____

Last Name: _____ **Suffix:** _____ (Sr., Jr., etc.) **First Name:** _____ **Middle Initial:** _____

Other Name: _____ **Address:** _____

(Apt# or P.O. Box): _____ **City:** _____ **State:** _____ **Zipcode:** _____ - _____

Home Phone: (_ _ _) _____ - _____ **Work Phone:** (_____) _____ - _____ **Extension:** _____

Birthdate: _____ /_____ /_____ (month day year) **Sex:** ☐ Male ☐ Female (check one) **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced (check one)

Employer: _____ ☐ **Full Time** ☐ **Part Time**

Employer Address: _____ **City:** _____ **State:**_____ **Zipcode:**_____

Referred by: _____ **Pharmacy Name & Phone:** _____ (___) _____
(Please be specific: Doctor, Patient, Ad, Insurance Co, etc)

PRIMARY INSURANCE COVERAGE

Primary Insurance: _____

Claims Address: _____

City: _____ **State:** _____ **Zipcode:** _____ **Phone:** (_____) _____ - _____

Responsible Party: ☐ Self ☐ Spouse ☐ Parent ☐ Other **Subscriber:** _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Dependent ☐ Other - _____

Subscriber's Address: _____ **City:** _____ **State:**_____ **Zip:**_____

Subscriber's Birthdate: _____ /_____ /_____ (month day year) **Subscriber's Social Security #** _____ - _____ -_____

Subscriber's Phone Number: (_____) _____ - _____ **Work Phone:** (_____) _____ - _____ **Extension:** _____

Subscriber's Employer:_____
(Name of Employer, Retired, None, or Full / Part-Time Student)

Employer Address: _____ **City:** _____ **State:**_____ **Zipcode:**_____

Effective Date of Insurance:_____ **Copayment:** $_____ **Policy #:**_____ **Group #:**_____

SECONDARY INSURANCE COVERAGE

Secondary Insurance: _____

Claims Address: _____

City: _____ **State:** _____ **Zipcode:** _____ **Phone:** (_____) _____ - _____

Subscriber: _____ **Subscriber's Address:** _____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Dependent ☐ Other - _____

Subscriber's Birthdate: _____ /_____ /_____ (month day year) **Subscriber's Social Security #** _____ - _____ -_____

Subscriber's Phone Number: (_____) _____ - _____ **Subscriber's Employer:**_____
(Name of Employer, Retired, None, or Full / Part-Time Student)

Work Phone: (_____) _____ - _____ **Extension:** _____

Employer Address: _____ **City:** _____ **State:**_____ **Zipcode:**_____

Effective Date of Insurance:_____ **Copayment:** $_____ **Policy #:**_____ **Group #:**_____

Driver's License #:_____ **Emergency Contact:**_____

Legal Guardian:_____ **Cell Phone / Pager:** _____

Mother's Work Phone: (_____) _____ - _____ **Father's Work Phone:** (_____) _____ - _____

PARTY RESPONSIBLE FOR CHARGES

For Workers Compensation, Accidents, etc.

☐ **(Check box if you are the responsible party)**

Bill To: _____

(Full Name - First, Middle, and Last))

Social Security # _____ - _____ - _____ **Claim Type:** ☐ Self ☐ Wrk Comp ☐ PIP ☐ MVA

Name: _____ **Address:** _____

(Apt# or P.O. Box): _____ **City:** _____ **State:** _____ **Zip:** _____

Case Type: _____ **File #:** _____ **Adjuster:** _____

Accident or Illness Onset Date: _____ /_____ /_____ **Accident State:** _____ **First Dr. Visit Date:** _____ /_____ /_____

Accident Description: _____

Accident Address: _____

FOR PEDIATRIC PATIENTS

Father's Name: _____

Address: _____

City, State, Zip: _____

Home Phone #: (_____) _____ - _____

Work Phone #: (_____) _____ - _____ **Ext:** _____

Mother's Name: _____

Address: _____

City, State, Zip: _____

Home Phone #: (_____) _____ - _____

Work Phone #: (_____) _____ - _____ **Ext:** _____

Patient's or Parent's Driver's License: _____ **State:** _____

Name of Legal Guardian: _____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____ **Home Phone:** (____) _____ - _____ **Work Phone:** (____) _____ - _____

CONSENT & ASSIGNMENT

PLEASE READ BEFORE SIGNING

***** Medicare *****

I authorize any holder of medical or other information about me to release to the Social Security Administration & Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim (Title XVIII). I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below. I understand that I am responsible for any health insurance deductibles, co-insurance (co-pay) and non-covered charges.

***** Blue Shield of Maryland *****

I understand the charge of a non-participating physician may exceed the Blue Shield of Maryland, Inc. payment and, if greater, I will be responsible for that amount. I authorize release of any medical information necessary to process this claim. For charges of a participating provider, I understand that I am responsible for any health insurance deductibles, co-insurance (co-pay) and non-covered charges.

***** Legal Assignment ***** (applicable to Physician Services)

The undersigned expressly agrees that if, upon default, this matter is referred for collection, the undersigned agrees to pay an attorney's fee of fifteen percent (15%) of the outstanding balance at the time of referral, which percentage and the amount resulting therefrom are considered reasonable by the undersigned, and any and all court costs incurred therewith, as well as private process server fees.

***** Insurance Assignment *****

I authorize and assign payment directly to the physician involved in my treatment and authorize release of medical information necessary to process the claim. I further understand I am financially responsible for charges **not covered** by my insurance.

*****Managed Care *****

I understand that, without an authorization/referral form from my HMO/PIPA/PPO, I will be financially responsible for charges I incur.

*****GUARANTEE *****

As an inducement for the providing of services to the patient, the undersigned absolutely and unconditionally guarantees to MFC and its successors and assigns, the full and complete payment due by the patient, as and when the same becomes due.

Signature: _____ **Date:** _____ /_____ /_____

(sign here)

***** Signature of Patient, Responsible Party, Parent, or Legal Guardian *****

Sign Here: _____ **Date:** _____ /_____ /_____

I authorize a copy of this authorization to be used in place of the original.

Acknowledgement of Notice of Privacy Practices

I acknowledge that I received Mercy Health Services' Notice of Privacy Practices. I understand this notice describes how medical information about me may be used and disclosed, my rights regarding the use and disclosure of this information, and how I can obtain access to this information.

_____ _____

Signature Date